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Wendell J. Newcomb

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G. Dekle Taylor

Enlarged Prostate, Its Surgical Management
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Intramedullary Pin Fixation in Femoral Fractures

WENDELL J. NEWCOMB, M.D.
PENSACOLA

A small series of 9 cases of application of the intramedullary pin in the femoral shaft is presented to outline the greatly improved method of treating this fracture. This method was endorsed by the Fracture Committee of the American Board of Orthopedic Surgery in 1949. It was then stated by Dr. Mather Cleveland that intramedullary fixation was the method of choice in treating fractures of the femoral shaft 2 inches below the lesser trochanter and 4 inches above the condyles. Many thousands of intramedullary pins have been applied since this statement was made, and remarkable results have been obtained, but much has been learned about complications of this apparently simple method.

Any fracture in the area mentioned by Dr. Cleveland may be handled in this manner. Usually the patient is placed in balanced traction prior to the insertion of the pin. This gives the patient time to overcome the original shock. Also, the surgeon has an opportunity to study the patient and build up his protective factors against infection. The pins have been inserted immediately in cases of compound fracture, but as shown in case 8 (table 1 and fig. 9), a more conservative method may be followed by allowing the original debridement wound to close prior to the fixation operation. Comminuted fractures may be held in place by circular wire, nylon or silk, or screws may be placed in the cortex of the bone adjacent to the pin in the medullary canal. Strong callus must be present before weight-bearing is allowed in comminuted fractures, or shortening may occur. Such shortening is demonstrated in the 47 year old patient in case 2 (table 1 and fig. 3), who walked before permission was granted.

The instruments used for nailing depend on the type of nail used. In all of the cases of this series the Hansen Street nail was employed. The equipment and nails are shown in figure 1. There are several problems; one, the length of the nail; two, the diameter of the intramedullary canal; and three, the contour of the femoral shaft.

The measurements of the length and the diameter of the canal and the normal contour of the femur may be made by obtaining a roentgenogram of the uninvolved femur with a nail of known length and diameter taped to the lateral surface of the skin, parallel to the femoral shaft. Another method of obtaining the approximate length is to measure from the knee joint to the greater trochanter and subtract 4 cm. The correct diameter can always be determined at operation by inserting

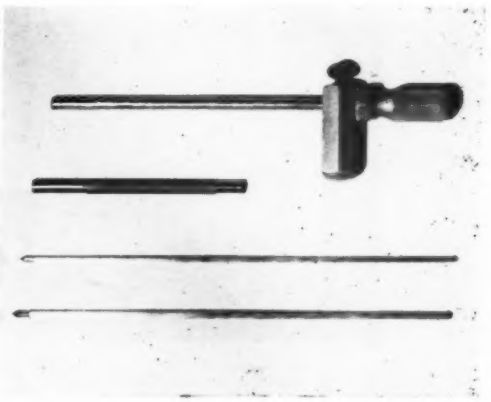
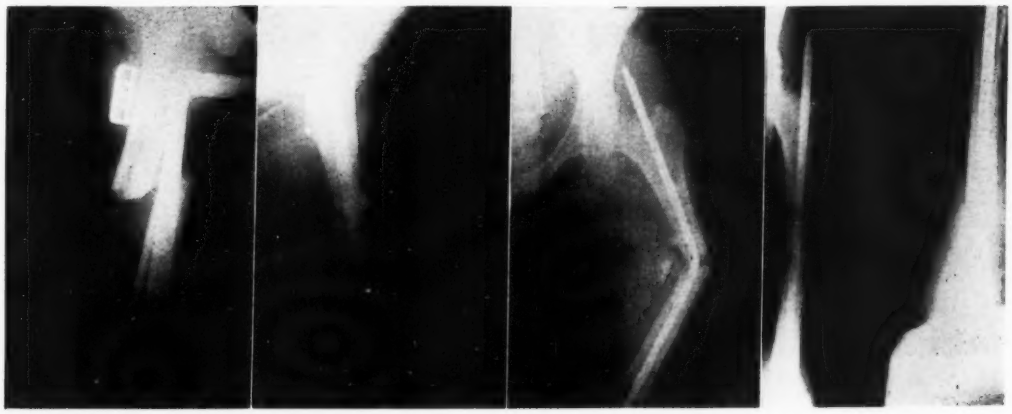


Fig. 1.—Top to bottom: driver and extractor, 9 mm. pin, and 11 mm. pin.

Table 1.—Analysis of Cases

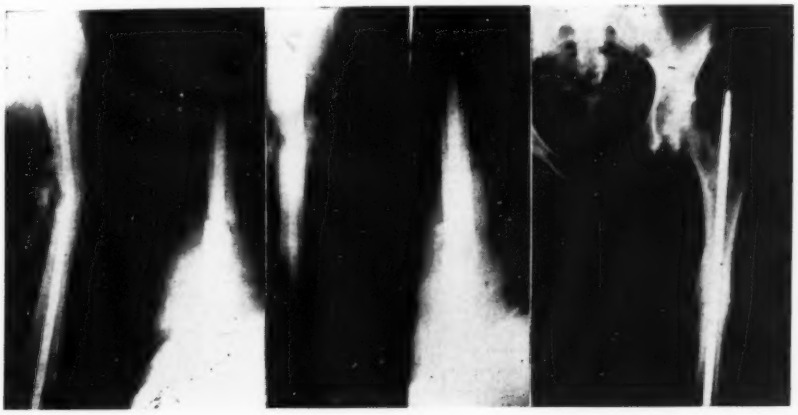
CASE	AGE	SEX	TYPE OF INJURY	LOCATION	ASSOCIATED CONDITIONS	HOSPITAL DAYS		POSTOPERATIVE DAYS BEFORE CRUTCHES	LIGHT DUTY	REGULAR DUTY	MOTION OF KNEE AND ANKLE	PIN REMOVED	HOSPITAL DAYS	COMPLICATIONS
						Before Surgery	After Surgery							
1	20	F	Comminuted fracture, left femur	Upper third of shaft	Cerebral concussion, mild	1	20	18	7 mos.	10 mos.	Complete	11 mos.	2	Bent pin twice, 2 mos and 5 mos. delayed union
2	47	F	Oblique, compound comminuted fracture, left femur	15 cm. distal to greater trochanter	Compound fracture, left forearm, maceration, face about nose	18	14	None, walked with aid in 6 wks.	2 mos.	4 mos.	Complete	5 mos.	2	5/8 in. shortening
3	17	F	Transverse fracture, left femur, simple, complete	Mid-shaft	Fracture, left proximal tibia, right foot	10	18	21	3 mos.	5 mos.	Complete	7 mos.	4	None
4	18	F	Fracture, right femur	Lower third	Severe contusion, right knee	15	10	60	5 mos.	7 mos.	Complete	6 mos.	8	20° rotation external; ½ in. shortening
5	35	M	Old fracture, left femur with severe angulation		Deformity, anterior bowing and 10 cm. shortening	3	27	25	5 mos.	6 mos.	Complete	Not removed to date	....	Delayed union
6	18	M	Comminuted fracture, right femur with 2 separate fragments	Mid-shaft	Fracture, distal fibula at left ankle	15	20	12	4 mos.	5 mos.	Complete	5½ mos.	2	None
7	11	M	Re-fracture, right femur	Mid-shaft transverse	Screws in previous fracture site	4	16	21	4 mos.	5 mos.	Complete	8 mos.	8	None
8	20	M	Compound fracture, right femur; fracture, left femur	Middle third	Fracture, right tibia	22	28	36	3½ mos.	.....	Right knee, 180°-60°; left knee, complete	Not removed 5 mos.	 1	5/8 in. shortening None
9	23	F	Fracture left femur	Union of middle and upper thirds	Laceration of face; shock, severe, 6 mos. pregnant	10	13	21	.....	.....	Complete	Not removed to date	....	None



COMMINUTED FRACTURE | AFTER REDUCTION | BENT PIN 2 MOS. AFTER FRACTURE | STRAIGHTENED PIN

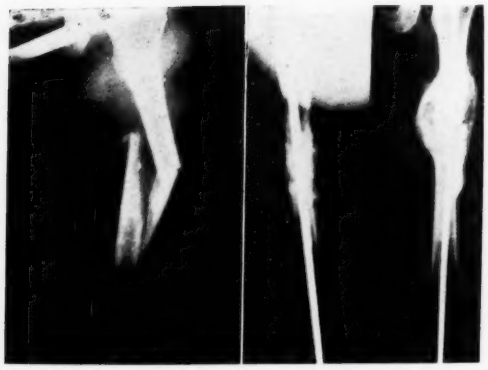
Figure 2a, Case 1

a 9 mm. pin into the shaft of the femur, then estimating whether or not an 11 mm. pin would pass readily. The isthmus of the canal is the smallest point. For the insertion, the patient is placed on the uninvolved side with the thighs flexed about 40 degrees and the knees flexed 90 degrees. The incision can be made anterolateral or posterolateral. The posterolateral incision is usually the incision of choice for if a hematoma develops, it will frequently drain spontaneously and avoid the possibility of infection arising in this culture material. The anterolateral incision often does not require as much separation of muscle as would be expected, for the muscles are frequently torn about the fracture. Little periosteal elevation is necessary to expose and approximate the ends of the bone, this being another advantage over the plate method of femoral fixation. Minimal periosteal elevation leads to rapid healing because of unaltered circulation of the fragments.



REBENT PIN, 4 MOS. AFTER FRACTURE | NEW PIN WITH BONE GRAFT | HEALED, 9 MOS. AFTER FRACTURE

Figure 2b, Case 1

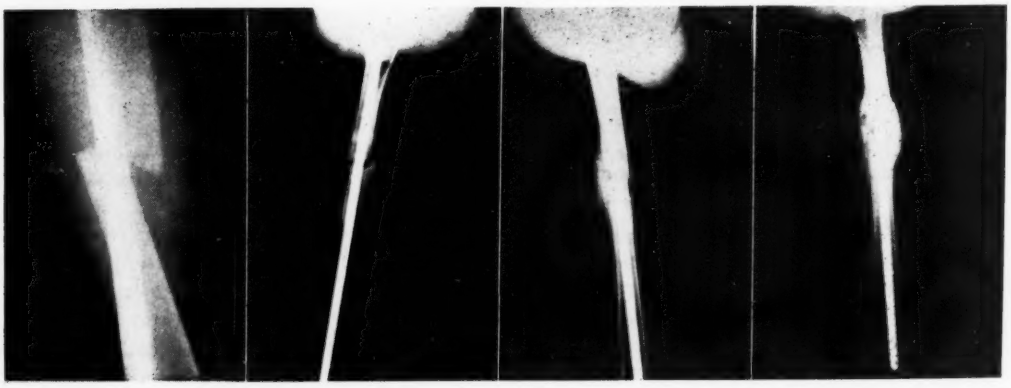


COMPOUND COMMINUTED FRACTURE

BONE GRAFT IN CALLUS

Figure 3, Case 2

The pin, which has been selected for the proper length and proper diameter is driven proximally, and it will readily be detected when the sharp end contacts and later breaks through the superior cortex of the trochanteric area. The pin will then protrude in the buttock, and a small incision allows it to extrude. The skin about the pin is covered, and the pin is driven proximally until the lower end is about ½ cm. below the distal end of the proximal fragment. The fragments are then approximated and aligned. The fragments can readily be held with a clamp while the pin is then driven distally. As the top of the pin approaches the greater trochanter, roentgenograms



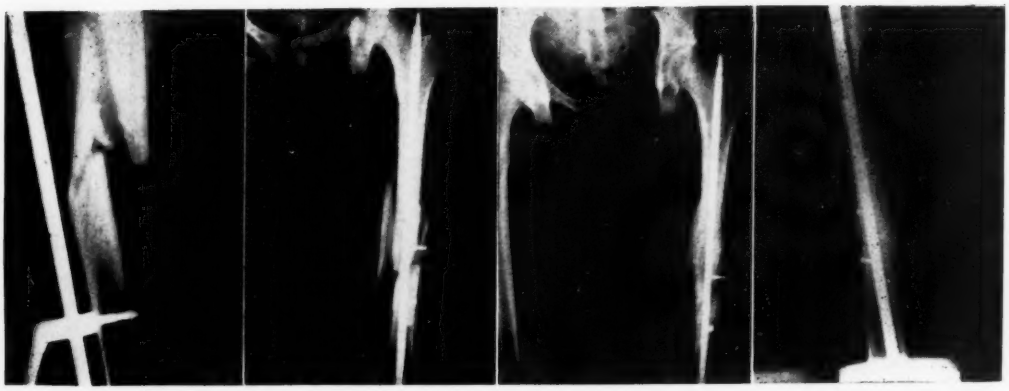
SIMPLE COMPLETE FRACTURE

NOTE BONE GRAFTS

NOTE BONE GRAFTS

7 MOS. POSTOPERATIVELY GRAFTS INCORPORATED

Figure 4, Case 3



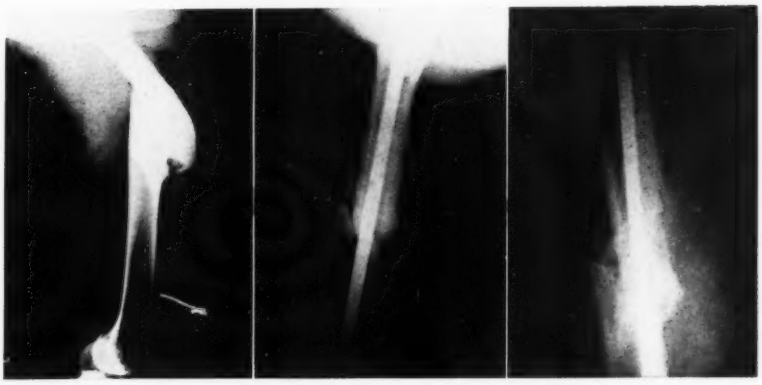
SIMPLE COMMINUTED FRACTURE

BONE GRAFTS POSTOPERATIVELY

BONE GRAFTS INCORPORATED

BONE GRAFTS INCORPORATED

Figure 5, Case 4



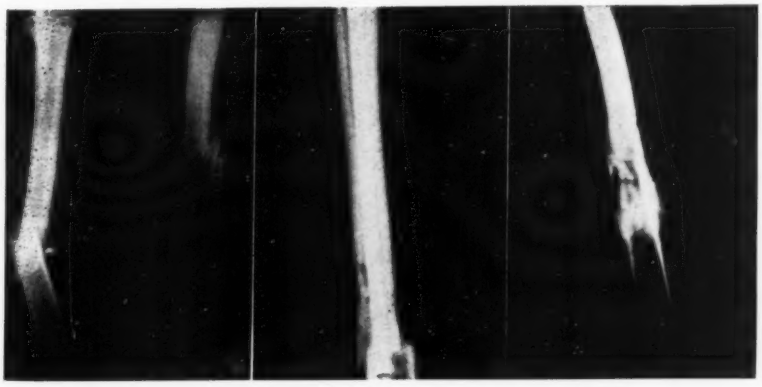
40° ANTERIOR ANGULATION | 2 MOS. POSTOPERATIVELY | 6 MOS. POSTOPERATIVELY

Figure 6, Case 5

of the knees should be taken in two planes to evaluate the position of the pin in relation to the articular cortex.

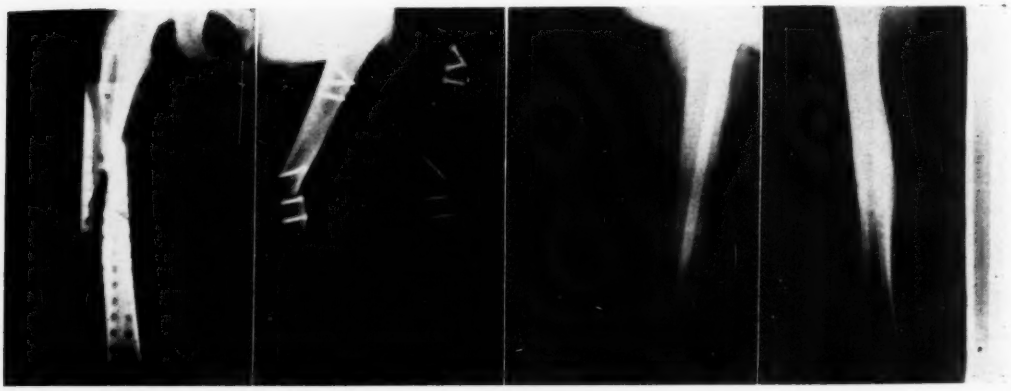
The pin should not protrude more than 1½ inches above the trochanter. This provision will avoid the pain in the buttock caused by irritation from the prominent sharp upper end. Caution should be used in the alignment of the fragments, for here is a possible chance of complication. If the fragments are angulated, the nail may penetrate the cortex, or, if rotation is not correct, it cannot be corrected later.

This type of fixation is of particular value in that it allows early activity of the muscles; thus motion of the joint is not impaired, and swelling is decreased. Blood flow is said to be twenty times greater in active muscles than in muscles during rest.[1] In only 1 of the cases presented was the knee joint limited in motion; in this extremity the femoral and tibial fractures were compound, and there was a large laceration at the knee which extended 4 or 5 inches along the femoral shaft. Much of the quadriceps muscle and tendon was lacerated above the knee. Even in this case, at six



SIMPLE COMMINUTED FRACTURE | 6 WKS. POSTOPERATIVELY | 6 MOS. POSTOPERATIVELY

Figure 7, Case 6



OBLIQUE COMMINUTED FRACTURE | REFRACTURE AFTER 7 MOS. | BONE GRAFTS POSTOPERATIVELY | PIN OUT, 8 MOS. POSTOPERATIVELY

Figure 8, Case 7

months the knee motion was 80 per cent of normal.

The normal motion greatly decreases disability as compared with other methods of treating these fractures. Early ambulation is of added advantage, but great care should be taken to avoid false security. As shown in case 1, the intramedullary pin will not support weight, and weight-bearing cannot be permitted until sufficient callus is present. The pin may not bend, but such possibility is present until the callus is sufficient to bear weight. It is considered wise to prolong the use of crutches and encourage the patient to walk with a stiff knee until abundant callus is present.

Bone grafting at the time of fracture fixation is popular with some surgeons.[2] This is one way to help prevent such complications as occurred in case 1 (bent pin), for abundant callus will develop rapidly when small pieces of homogenous or bone bank bone are placed adjacent to the fracture site.

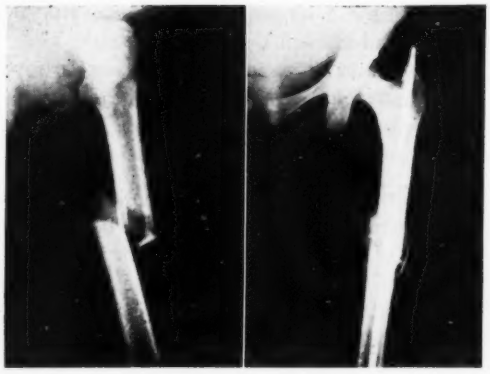
Analysis of the 9 cases of this series can be quickly made by reference to table 1 and figures 2 to 10.

Conclusion

Intramedullary pin fixation in femoral fractures permits early motion, decreases hospital stay and nursing care, and overcomes the depressing

LEFT TRANSVERSE FRACTURE | RIGHT TRANSVERSE FRACTURE | BILATERAL VIEW HEALED IN 5 MOS.

Figure 9, Case 8



SIMPLE TRANSVERSE FRACTURE

NOTE GRAFT AND ABUNDANT CALLUS AT 6 WKS.

Figure 10, Case 9

confinement of a hip spica cast. Mention has been made of the complications, such as bent pin, and shortening and rotation of fragments, to help others avoid these pitfalls. Bone grafts aid in producing extracortical callus, thus allowing earlier motion and weight-bearing. Bone obtained from a bone bank shortens operative time, minimizes surgical shock, decreases postoperative pain and lessens convalescent time.

References

1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice: A Text in Applied Physiology, Philadelphia, Williams and Wilkins, 1950, p. 521.
2. Thompson, E. M., of Lincoln, Neb., verbal report.

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Diseases of the Parotid Gland

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The name parotid is derived from two Greek words meaning near and ear. Galen applied the name to an abscess of the ear. The function of the parotid gland and duct was described by Stensen in 1662.[1]

Embryology

The parotid glands are the first of the salivary glands to make their appearance. They become manifest during the sixth week by an ingrowth of oral epithelium into the underlying mesenchyme on the inner surface of either cheek and are believed to be derived from stomodeal ectoderm.

The ingrowth of epithelium is rapid and toward the ear. The main duct branches into primordial cell cords which form the parenchymatous part of the gland, consisting of the branch ducts and the terminal alveoli. The surrounding mesenchyme forms the connective tissue framework of the gland, which establishes septums dividing the gland into lobules.[2] Developing lateral to the main branch of the facial nerve, the gland so envelops this nerve that it is eventually surrounded by glandular tissue. The parotid gland is entirely an albuminous gland in that it secretes only serous watery liquid and no mucus.

Anatomy

This gland has a large superficial lobe connected by an isthmus to a smaller deep portion. This bilobate gland is bounded in part by the ramus of the mandible, which is covered by the masseter and internal pterygoid muscles. The posterior boundaries consist of the external auditory meatus, the tympanic plate and the base of the styloid process. Here it lies in close relationship to the posterior belly of the digastric, the stylohyoid and the sternocleidomastoid muscles laterally and the styloglossus and stylopharyngeus muscles medially. Anterior to the styloid process, the medial surface of the gland forms the lateral boundary of the lateral pharyngeal space. This relationship is one of clinical importance to the otolaryngologist.

The largest expanse of the gland is superficial where it is covered by the parotidomasseteric fascia, which is a continuation of the superficial layer

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of the deep cervical fascia. Closely adherent to the glandular substance, this fascia forms partitions which pass through the gland, making its dissection difficult. The superficial portion of the gland may extend up to the zygoma, over the masseter muscle and inferiorly to the stylomandibular ligament, which separates it from the submaxillary gland. A prolongation over the masseter muscle, which may be nearly distinct from the remainder of the gland, is known as the accessory parotid gland. Emerging from the front of the gland, the parotid duct traverses the masseter muscle and turns inward at its anterior border to pass through the buccinator muscle and oral mucous membrane opposite the second molar tooth.

The facial nerve leaves the temporal bone at the stylomastoid foramen medial to the mastoid and lateral to the styloid processes. It continues in an anteroinferior and lateral course to enter the parotid gland posteriorly. Soon after entering the gland, it usually divides into its two major trunks, the temporofacial and the cervicofacial. This division as a rule occurs in the region of the isthmus. The temporofacial trunk ascends above the isthmus, spreading out in the gland to form the temporal, zygomatic and buccal branches. Descending beneath the isthmus, the cervicofacial trunk divides in the gland, forming the mandibular and cervical divisions. The cervicofacial and temporofacial trunks arborize in variable patterns distal to the isthmus, and anastomoses have been demonstrated between these distal divisions.

Nerve Supply of the Parotid Gland

The craniosacral and thoracolumbar divisions of the autonomic nervous system supply the parotid gland with secretory nerves. The craniosacral fibers arise in the medulla from the inferior salivatory nucleus situated at the upper end of the nucleus of the glossopharyngeal nerve. These fibers travel with the glossopharyngeal nerve to the jugular foramen, where they separate from it in its tympanic branch. They leave the tympanic plexus in the trunk of the small superficial petrosal nerve which conveys them to the otic ganglion, where they communicate with ganglion cells from which postganglionic fibers arise. The auriculotemporal branch of the fifth cranial nerve transmits these postganglionic fibers to the cell of the gland.

The cell stations for the thoracolumbar fibers lie in the superior cervical ganglion. The preganglionic fibers arise from the upper one or two thoracic segments. The postganglionic fibers reach the gland by way of the plexuses of the external and internal carotid arteries.

The dilator fibers for the blood vessels travel with the craniosacral fibers and the constrictor fibers with the thoracolumbar fibers.

Allergic Parotitis

Failure to recognize a clinical entity which has long existed perhaps accounts for the dearth, until recently, of literature pertaining to allergic involvement of the salivary glands. Hansel[3] believed that, in many cases, the disease referred to as chronic recurrent parotitis is actually allergic in nature.

Allergy of the parotid gland is usually associated with other allergic manifestations, such as generalized urticaria, nasal obstruction with watery rhinorrhea, sneezing, asthma, lacrimation and headache. The painful swelling of one or both parotid glands may recur for variable periods of time. Zinder and Fraser[4] reported a case of allergic parotitis caused by exposure to turkey feathers and the ingestion of turkey meat and other specific foods, with complete relief obtained by elimination of the specific foods and the use of inhalant therapy. In the opinion of Waldbott and Shea,[5] the swelling may be due to an allergic edema of the ducts or glandular tissue, or to a blockage of the ducts by plugs of mucus similar to those present in the bronchi in bronchial asthma.

Ruling out other diseases, such as stone in the duct, and a history of allergy usually establish the diagnosis. Eosinophils are generally found in a smear made from the parotid secretion. Purulent secretion may be seen coming from the duct, owing to secondary infection superimposed on a dilation of the duct system caused by an allergic parotitis.

Treatment consists of the recognition of, avoidance of, and desensitization to the offending allergens.

Acute Inflammation of the Parotid Gland

With the advent of chemotherapy, antibiotics, and the judicious management of fluid balance, the incidence of acute suppurative parotitis and its complications has markedly decreased.

Furstenberg[6] was of the opinion that the long-recognized relationship between parotid abscess and major abdominal and pelvic operations is due to dehydration in the surgical patient for he had not observed the development of such an abscess in a patient in whom the fluid balance was adequately maintained. Lacking a protective flow of saliva, the dehydrated parotid gland may be sub-

ject to infection by a retrograde extension of bacteria from the mouth. This author believed the parotid gland may be injured by the anesthetist in forcibly placing his fingers over the mandible to hold the jaw forward during anesthesia. Such injury might make the gland less resistant to infection. The present use of the endotrachial tube for prolonged anesthesia minimizes this possibility.

Acute suppurative parotitis occurs in the newborn, 30 to 40 per cent of the cases occurring in premature infants.[7] Injury at birth, poor oral hygiene, puerperal disease in the mother, and cracked or diseased nipples are probable causes.

Recurrent bouts may result from calculi in the gland or in Stensen's duct. The hematogenous or lymphogenous spread from distant or adjacent structures is an etiologic factor. When associated with debilitating disease, the parotitis is usually caused by dehydration and poor oral hygiene. Suppuration in the lateral pharyngeal space may spread by direct continuity to the medial aspect of the parotid gland.

Massive doses of antibiotics and chemotherapy should be instituted at once. The agent of choice depends upon the organism isolated. Sound principles of body fluid balance, as described by Coller and Maddock,[8] should be followed. Adequate hydration re-establishes salivation and allows the gland to clear itself of bacteria, thus preventing further retrograde extension. Good oral hygiene is essential.

Roentgen therapy in doses of 100 r is given every two days for four doses. Calculi should be removed by incising the duct. When suppuration occurs, Furstenberg[6] advocated wide incision and drainage of the parotid gland. Beginning at the level of the zygoma, the incision extends down in front of the ear beneath the angle of the mandible and forward for 2 to 3 cm. The skin and subcutaneous tissues are reflected forward, and several incisions are made horizontally into the substance of the gland to provide massive drainage.

Xerostomia

True xerostomia, or dry mouth, is a relatively rare condition of obscure etiology. The patient complains of excessive dryness of the lips and mouth and of difficulty in swallowing and chewing because of the lack of saliva. When saliva is present, it is usually thick and mucoid in nature.

The mucous membranes are parched, and pressure over the salivary glands and their ducts expels little saliva. The tongue is rough and fissured; dried crusts may be present on the surface. The pharynx and hypopharynx are usually especially dry and crusted.

Xerostomia is not to be confused with the complaint of dry mouth unsubstantiated by objective findings. The patient with the latter complaint generally manifests other functional complaints and frequently complains of a burning tongue. As a rule, he has resorted to numerous vitamins, mouth washes and multiple forms of therapy without noted improvement. This type of patient should be directed to a psychiatrist rather than to the corner drugstore for further vitamin therapy.

Disease of only one or two of the salivary glands does not result in symptoms of impaired salivation.

Numerous etiologic factors have been suggested. Greenbaum and Tumen[9] reported a case following roentgen therapy for hypertrichosis. In this type of case the pathologic change is probably due to atrophy and scar tissue replacement of the glandular tissue. Congenital xerostomia may occur through an absence or underdevelopment of the salivary glands. A familial tendency has been demonstrated for this disease.[10] If sufficient salivary tissue is destroyed in such diseases as Mikulicz's disease, sarcoidosis and lymphoblastoma, dry mouth may result.[10] Furstenberg and Crosby[11] mentioned the causal effect of exposure to organic dust and zinc poisoning. It has been demonstrated that psychiatric disorders may depress salivary activity. Saphir[12] successfully treated a case of xerostomia with nicotinic acid and suggested that nicotinic acid deficiency should be included among the etiologic factors.

Noting the relationship between dryness of the mouth and dryness of the eyes (keratoconjunctivitis sicca), Allington[10] stated that there also may be an associated dryness of the nose, throat and vagina and a deficient gastric secretion. Frequently, rheumatoid arthritis is an associated condition. This author designated this set of symptoms as Sjögren's syndrome, naming it for the Swedish ophthalmologist, Henrick Sjögren, who first described the relationship in 1933. Most frequently this syndrome occurs in women in the postmenopausal period. Allington[10] was of the opinion that hormonal insufficiency may be etiologically important. He noted similarity between this syndrome and the changes occurring in Plummer-Vinson syndrome, pernicious anemia, iron deficiency anemia, and deficiency of vitamin A, nicotinic acid and riboflavin.

It was the conclusion of Furstenberg and Crosby[11] that the pathologic change responsible for xerostomia is usually not demonstrated. They regarded the onset of salivation after the administration of pilocarpine as proof of some disorder in the secretory fibers since pilocarpine has a predilection for the end organs of the secretory nerves.

The treatment of xerostomia has been, in general, rather unsatisfactory. Furstenberg and Crosby[11] advocated the oral use, for three to six weeks, of pilocarpine hydrochloride or pilocarpine nitrate in 10 mg. doses three times a day before meals. The patient should be left in a mild state of acidosis by restricting alkalies and administering 3 Gm. of ammonium chloride with meals three days on and two days off during the uninterrupted administration of the pilocarpine. Acetylcholine, which initiates the nerve impulse of the secreting fibers, is less rapidly broken down by cholinesterase in an acid medium. In selected cases, hormonal therapy, vitamin therapy and psychotherapy should be instituted.

Case 1. — R. T. L., a white male accountant aged 43, complained of a consistently dry mouth, difficulty in swallowing and chewing food, inability to chew gum because of the lack of saliva, and almost no perspiration on exertion. He had acquired dryness of the mouth and lips while serving with the armed forces in Central America seven years prior to consulting me. For ten months, he had been on a deficiency diet consisting of meat and potatoes with fruits and vegetables lacking.

The results of physical examination were normal except for a dryness of the mouth, pharynx, nasopharynx, larynx and nasal mucous membrance. There was also diminished lacrimation. Pressure over Stensen's duct failed to express any saliva, but pressure over Wharton's duct yielded a thick mucoid saliva.

The patient received 10 mg. of pilocarpine hydrochloride three times daily one-half hour before meals continuously and ammonium chloride 3 Gm. three times daily with meals three days on and two days off for a period of three weeks. For approximately an hour following administration of the pilocarpine, he noted an increase in saliva to an extent greater than at any time during the preceding seven years. Perspiration was profuse during the period of increased output of saliva. There was no improvement in the flow of saliva after the pilocarpine was discontinued. He then received vitamin therapy for two months with no appreciable change in symptoms.

Ptyalism

The opposite of xerostomia, ptyalism is an excessive secretion by the salivary glands. It may be due to excessive central excitation[13] or to reflexes excited by irritating lesions in the mouth or esophagus. It occurs commonly in carcinoma of the mouth, pharynx, larynx and esophagus. It may be functional in nature.

Atropine is the treatment of choice. The irritating lesions should be removed if possible. Sectioning of the auriculotemporal nerve has been advocated in resistant cases.

Fistulas

The commonest cause of fistula of the parotid gland is traumatic laceration of Stensen's duct. Inadvertently, the duct may be entered during surgical procedures in the vicinity. Fistula of the gland substance occurs less frequently and is less troublesome. Rarely, fistula follows a wide dissection of the gland in repair of the facial nerve and removal of parotid tumors in a noninfected field. It occurs more frequently after incision of a parotid abscess, and may occur with acute and chronic infections and ulcerating neoplasms.

Glandular fistulas involving small tributaries of the ductal system often close spontaneously owing to the formation of scar tissue with occlusion of the involved duct. This process may be hastened by local pressure, chemical or electrical cautery, or roentgen therapy. In dealing with more extensive fistulas, as those observed in ulceration of the gland, some advocate avulsion of the auriculotemporal nerve. This deprives the gland of its secretory fibers through the craniosacral nerve supply. The nerve runs parallel and posterior to the vertical portion of the temporal artery. The portion of the nerve central to the gland is avulsed.[14]

Treatment of fistula of Stensen's duct presents a more formidable problem. It is estimated that one parotid gland secretes approximately 500 cc. of saliva daily.[15] The diversion of this stream from a well formed fistula to a reconstructed duct is technically difficult.

In 1945, Wallace[16] reported the successful primary repair of a lacerated duct and described the procedure. A year later, Newman and Seabrook[17] reported that during World War II they successfully closed 5 salivary fistulas of variable duration by surgical repair of the duct. They presented their technic in detail.

Some roentgenologists consider roentgen therapy the treatment of choice for parotid fistulas. The rationale for this therapy is the temporary suppression of the salivary flow in order to give the fistula a better chance to close spontaneously. Popma[18] advised immediate roentgen therapy for traumatic injuries of the parotid gland to prevent fistula formation. Administering 400 r on two succeeding days, Portmann[15] used 800 r as measured on the skin over the parotid gland in 3 cases with gratifying results. He observed that the function of the gland may be resumed in four months and that meanwhile the fistula will usually have closed. He advocated roentgen therapy first for all

parotid fistulas, and if it fails, then operative repair may be attempted.

Sialolithiasis

Calculi occur rarely in the parotid gland or duct. The causative factor is believed to be the precipitation of the salts of calcium, magnesium, sodium and potassium, or a minute foreign body, or precipitated mucin in the duct. In a review of 110 cases of sialolithiasis, New and Harper[19] reported the relative incidence in the salivary glands and their ducts as submaxillary 92.9 per cent, parotid 4.3 per cent, and sublingual 2.8 per cent.

Usually intermittent in character at the onset, swelling is accompanied by severe pain in the region of the gland or duct and is worse during meals. Both often subside in a few hours. With increased obstruction secondary infection occurs, followed by continuous pain, swelling, and tenderness of the gland. Purulent secretions may be expressed from the orifice of the duct, and the gland manifests classical symptoms of inflammation. If the stone is not removed, suppurative parotitis may ensue.

In most cases, the stone can be palpated with a probe in the duct and can be demonstrated roentgenologically. A calculus in Stensen's duct is removed under local anesthesia by inserting a probe in the duct and incising the duct along the probe to the stone, which is then removed. The incised duct is not sutured and heals well in several days. Small calculi, however, may remain in the duct for long periods of time, causing fibrotic changes resulting in stenosis with symptoms of recurrent obstruction.

Case 2. — G. M., a white man aged 29, first consulted me on June 22, 1950, complaining of intermittent swelling and pain over the left parotid gland and a lump in the left cheek. The onset of these symptoms occurred in 1945 while he was serving in the Navy. At that time the region over the left parotid gland was painful, red and swollen, increasingly so during meals. The swelling subsided after he had received penicillin for one week. During the five year interval, he had been conscious of a painful lump in the cheek, but had experienced no further episodes of swelling in the parotid region. For several months prior to consulting me, he had noted increased swelling of the left parotid gland during meals. Drinking alcoholic beverages increased the swelling and caused severe pain.

Physical examination gave negative results, except for the left parotid duct. Saliva containing stringy mucin could be expressed from the orifice. Palpation anterior to the left masseter muscle revealed a firm tender mass approximately 1 by 2 cm. in diameter. A probe in the duct could not be passed beyond this mass. No stone was palpable, but roentgen examination gave evidence of a small stone in the duct.

On July 11, with the patient under endotracheal nitrous oxide ether anesthesia, a probe was inserted to the point of obstruction, and the duct was incised. Two stones, one approximately 3 mm. and the other 7 mm. in greatest diameter, were removed. Proximal to the stones, there was palpated a fibrous tissue mass through which a probe could not be passed. The mass was excised by sharp dissection. The duct proximal to this area appeared dilated. Normal-appearing saliva was expressed. The edges were sutured to the buccal mucosa with 4 small dermalon sutures.

The microscopic description of the specimen follows: "Four sections through the salivary duct show an extremely dense fibrocollagenous type of tissue surrounding a small epithelial-lined duct, the cells of which appear to be essentially normal. A large number of extremely thick-walled vascular channels are seen in the dense fibrocollagenous tissue surrounding the epithelial-lined channels. Here, also, are large numbers of chronic inflammatory cells and spotty areas of calcification. No definite evidence of neoplasia is noted." The pathologic diagnoses were: "(1) Fibrosis and hyalinization in periductal tissue. (2) Chronic inflammation and calcification in periductal tissue."

The patient received procaine penicillin, 400,000 units daily for four days. He was discharged from the hospital on the third postoperative day, the stitches were removed on the seventh postoperative day, and recovery was uneventful.

On March 8, 1951, he stated he had had no more pain or swelling of the left parotid region. There was a free flow of saliva from Stensen's duct. The sphincteric function of the duct was absent. Slight pressure over this area resulted in a copious flow of saliva, while firm pressure over the parotid region on the right side expressed only a scant amount. Instead of the usual pin-point opening of the papilla, there was a vertical slit. The loss of the papilla may make the duct and gland more susceptible to infection from the contents of the mouth. Newman and Seabrook[17] stressed the importance of preserving the sphincteric and valvular action of the papilla when possible. As yet, the patient has experienced no ill effects as a result of this loss.

Solitary or multiple stones may occur in the gland proper. They may be removed by reflecting the skin and subcutaneous tissues over the gland, palpating the stones and excising them from the parenchyma of the gland.

Parotid Tumors

The differential diagnosis of parotid tumors must include tumefactions resulting from inflammatory lesions, tumors of connective, vascular and nervous origin, and neoplasms arising from the parenchyma of the gland itself.[20]

Chronic recurrent parotitis may produce a firm nodule in the gland simulating a tumor. Howard and his associates[20] preferred biopsy to resection as no serious sequelae have been reported from this condition. Parotidectomy for this type of lesion has resulted in facial paralysis.

Parotid cysts may result from atresia of the ducts secondary to previous inflammatory changes. These should be excised.

Hemangioma and hemangioendothelioma usually occur during the first year of life. As a rule, these tumors are benign and are treated either by irradiation or a combination of irradiation and surgery. The cavernous type of hemangioma may be lethal because of its rapid extension and resistance to roentgen therapy.

Neurofibroma, lipoma and sarcoma occur rarely in the parotid gland. They should be removed surgically.

Papillary cyst adenoma lymphomatosum, also known as adenolymphoma or Wharthin's tumor, is composed of papillary epithelial projections in a lymphoid stroma. The origin is uncertain, but it is thought to be due to an embryonal rest from the first bronchial cleft. It is a benign lesion, occasionally bilateral, occurring mostly in males. The treatment is surgical excision. The tumor rarely recurs if completely excised.

The majority of parotid tumors are classified as mixed tumors of the salivary glands. The literature contains much theorizing as to their etiology. These tumors contain epithelial cells which often assume a glandular architecture, surrounded by myxomatous material which stains like cartilage. Scattered through this matrix are connective tissue and occasionally lymphoid tissue and bone. These tumors do not imitate the normal structures of salivary glands and may be found at distant sites, such as the tongue, nasopharynx, hard palate and nasal accessory sinuses. It is generally accepted that these tumors are derived from rests of embryonal ectoderm owing to some disturbance in embryonic development.

Tumors of this type usually occur between the second and fourth decades. The onset is as a rule marked by a painless mass in front or behind the mandible. The flow of saliva is normal, and it is usually clear. There is a gradual increase in the size of the tumor, and its presence may be unknown to the patient until a period of rapid growth occurs. A firm well defined mass is palpable in the superficial portion of the gland. It is less well defined in the deep portion. Benign mixed tumors do not cause a facial paralysis. These tumors may increase gradually in size for ten to twenty years and then increase rapidly. The patient usually does not seek surgical relief for an average of seven years.[6] In negligent patients, these tumors may obtain enormous size. Those located in the inner prolongation of the gland may extend through the lateral pharyngeal space and displace the tonsil and palate medially.

A wide discrepancy of opinion as to treatment exists in the literature. Some authors advocated deferring surgery until the patient has discomfort or there is a suspected or known malignancy of the tumor.[21] McFarland[22] advised the postponement of an operation until the tumor is "ripe," or about the size of a lemon. Others advocated surgical removal as soon as a tumor of this type is discovered.[23,24]

Buxton, Maxwell and Cooper[23] believed this discrepancy of opinion is due to a pessimistic attitude which has prevailed in the past. A lack of exact knowledge of the anatomy of the facial nerve and its branches has made the surgeon hesitant in the removal of the mixed tumors for fear of a postoperative facial paralysis. The belief that these tumors recur and with each recurrence there are increased cellularity and potential malignant change has long been accepted. Further pessimism has been manifested in the belief that if the tumor is carcinoma, excision fails to offer much benefit. These authors in reviewing a series of 227 cases of primary tumor of the parotid gland, of which 113 were benign mixed tumors, found only 3 cases in which there was a definite change from a benign to a malignant lesion in a mixed tumor following the initial excision. In these 3 cases there was an interval of ten to twenty years between the initial excision and recurrence. They concluded that time rather than surgical trauma is the important factor in the development of malignant change in a benign mixed tumor.

The average recurrent rate in the literature has been approximately 25 per cent.[25] McFarland[22] observed that the smaller tumors recur about twice as fast as the larger ones. He believed that smaller tumors are more apt to have small undiscovered outlying lobules that are left behind during operation. The onset of the recurrence may occur up to twenty or thirty years after excision of the original tumor. Several reasons for the high recurrence rate have been given. The inadequate excision of small tumors under local anesthesia probably accounts for the high recurrence rate in small tumors.[23] The tumors may be of multicentric origin, having other foci in the gland substance. Small satellite tumor cells may exist outside of the capsule. Klopp and Winship[26] demonstrated "seeding" of the gland following removal of these tumors with recurrence at the involved sites. They also demonstrated tumor cells in the capsule of a mixed tumor and they believed that enucleation of the tumor does not adequately remove all tumor cells.

Stein and Geschickter[27] reported a recurrence rate of 50 per cent following enucleation of a mixed tumor as compared with that of 13 per cent following excision of the tumor with a margin of parotid tissue. Klopp and Winship[26] advocated subtotal parotidectomy with almost complete removal of the parotid gland to prevent recurrence of mixed tumors. Brown, McDowell and Fryer[28] reported successful removal of 75 mixed tumors

with no paralysis of the facial nerve and no recurrence over a period of ten years. They advocated a wide exposure of the gland and removal of the tumor with the capsule intact. Irrigation of the wound with copious quantities of saline is carried out to remove any contamination with tumor cells. Buxton, Maxwell and Cooper[23] reported a recurrence rate of mixed tumors of 10.9 per cent in a group of 113 patients, for 57 of whom the postoperative interval was less than five years. They advocated visualization of adjacent branches of the facial nerve and resection of the intact tumor with a wide margin of adjacent parotid gland.

The technic employed by Buxton, Maxwell and Cooper[23] in the removal of parotid tumors and in exposing the main trunk of the facial nerve and its branches when dealing with these tumors follows: The incision begins just below the zygoma and immediately in front of the tragus, extending vertically to 1 to 2 cm. beneath the lobule of the ear and posterior to the angle of the mandible, where it is curved forward along the posterior belly of the digastric muscle. The skin and subcutaneous tissues of the flap are reflected forward, exposing widely the surface of the parotid gland. Normal glandular tissue usually has to be incised to expose the capsule of the tumor. Prior to incision of the glandular tissue, the electrode of a faradic stimulator is passed over the tissue to be incised. If no facial movements are incited with 2 to 3 volts, one may reasonably assume that incision into the glandular tissue is safe. Maxwell devised an excellent stimulator for use in cases of this type and for work involving the facial nerve in the temporal bone.

Tumors arising in the deep portion of the gland may produce atrophy of the superficial glandular tissue and displace the facial nerve far from its normal course. The tumor, its capsule and a margin of normal parotid tissue should be removed without rupturing the capsule. Tumors in the superficial portion of the gland may rest on branches of the facial nerve. One must be careful in dissecting the mesial portion of the tumor to avoid injuring the nerve.

When tumors lie in the deep portion of the gland, the nerve may be displaced upwards, inferiorly or laterally. Buxton and his associates[23] advised isolating the facial nerve prior to dissection of the tumor. They advocated several different methods for exposure of the nerve. When the tumor is large and encroaches upon the stylomastoid foramen, the zygomatic branch of the nerve which lies inferior and parallel to the zygomatic process may be isolated and traced posteriorly to the main trunk of the nerve. A similar method is to isolate the mandibular branch beneath the ramus of the mandible and trace it posteriorly. The mastoid tip may be removed and the nerve isolated at the stylomastoid foramen and traced forward. The method most frequently used by these authors was devised by Maxwell. The posterior aspect of the gland is separated by sharp and blunt dissection from the perichondrium of the external auditory canal down along the tympanic plate of the petrous bone to the base of the styloid process. The main trunk of the facial nerve is identified as it passes first lateral to the base of the styloid process and is then traced anteriorly to the pes anserinus. The faradic stimulator is of great value in all of these technics.

Some advocate the use of roentgen therapy in conjunction with surgical removal of parotid tumors. The epithelial elements of the mixed tumors are thought to be sensitive to roentgen rays even though the myxomatous tissue is insensitive. The capsule is believed to be thickened by roentgen therapy, thus facilitating removal. Buxton and his associates[23] did not recommend roentgen therapy in the treatment of mixed tumors because there is little evidence that complete destruction of a mixed tumor is obtained without extensive damage to normal structures.

Carcinoma

Carcinoma of the parotid gland is usually divided into two groups, the lesions arising in mixed tumors and those primary in the gland, generally of ductal origin. The latter group includes pseudoadenomatous basal cell carcinoma, squamous cell carcinoma, adenocarcinoma and the mucoepidermoid types of carcinoma. Sarcoma of the parotid gland is rare.

Buxton and his associates[23] concluded that the occurrence of pain or tenderness over the tumor is of little value in differentiating malignant lesions. A rapid change in rate of growth is not always diagnostic of a malignant change as this also occurs in benign tumors. Paralysis of branches of the facial nerve associated with a tumor of the parotid gland is usually diagnostic of an infiltration of the nerve by a malignant tumor. Fixation of the tumor to the skin in the absence of previous surgery or roentgen therapy is usually diagnostic of a malignant tumor. In the early stages of a malignant tumor it is not possible to differentiate it from a

benign lesion. The average duration of symptoms in a series of 18 cases of malignant tumor reported by Jones, Scarborough and Brown[29] was five years.

Since it is not possible to make an early diagnosis of malignant tumors of the parotid gland, it follows that the best therapy for these tumors is adequate excision as soon as a tumor mass is diagnosed, provided an inflammatory process has been ruled out. If the neoplasm has broken through its capsule, the entire gland should be removed, with sacrifice of the fibers of the facial nerve which are infiltrated with the neoplasm. If the fibers are not involved, they may be spared by careful dissection.

Buxton and his associates[23] did not advocate postoperative irradiation in well encapsulated mixed tumors which show malignant change if they have been completely removed with a surrounding layer of normal gland. If complete removal of a malignant tumor is uncertain, roentgen therapy is administered to the limit of tolerance of the normal tissues.

Miscellaneous Diseases

Mumps (Epidemic Parotitis). — Mumps is an acute communicable virus disease. It usually occurs in childhood and is characterized by painful enlargement of the salivary glands. One or both parotid glands are swollen. The submaxillary glands and less frequently the sublingual glands may also be swollen. The prodromal symptoms of fever, anorexia, headache, vomiting and generalized aches and pains suggest a generalized infection. The enlargement of the salivary glands is probably a local manifestation of the disease. Permanent immunity usually follows the disease. Numerous subclinical cases probably occur which also give a lasting immunity.

Epididymo-orchitis and meningoencephalitis are the commonest complications. Nerve deafness, usually unilateral, may result from mumps, probably due to a selectivity of the eighth nerve by the virus. Laryngeal edema and pitting edema over the sternum may occur because of pressure on the lymphatics of the neck.

Tuberculosis. — Tuberculosis of the parotid gland is rare. The gland may be invaded by ascending infection through the duct or by lymphogenous or hematogenous spread. There may be a localized or diffuse swelling of the gland. Diagnosis is usually made by biopsy. Hersh[30] reported a case successfully treated with 1 Gm. of streptomycin daily for six weeks,

Uveoparotitis (Heerfordt's Disease). — Uveoparotid fever is a rare disease which usually occurs in young persons. It is characterized by fever, bilateral uveitis, parotitis and palsy of certain cranial nerves, most frequently the seventh. The disease is chronic, but as a rule terminates in recovery although with considerable loss of vision. Because it is occasionally coexistent with and similar pathologically to Boeck's sarcoid, it is considered by some to be another form of sarcoidosis.[31] Treatment is nonspecific.

Mikulicz's Disease. — Of unknown etiology, Mikulicz's disease is characterized by symmetric swelling of the lacrimal, orbital and salivary glands. Microscopically, there is a massive lymphocytic infiltration of the glandular tissue with a few eosinophils, plasma cells and, occasionally, giant cells.[32] Mikulicz's syndrome appears similar clinically, but is a local manifestation of a systemic disease, such as leukemia, tuberculosis, lymphosarcoma, syphilis, toxic reaction or gout. Roentgen therapy is the treatment of choice in Mikulicz's disease.[33]

Auriculotemporal Syndrome. — The auriculotemporal syndrome is a comparatively rare condition of the parotid gland manifested by redness and sweating over the temporal and periauricular area, and usually occurs in connection with eating. Pain and sensory disturbances in the form of increased or diminished sensation in the distribution of the auriculotemporal nerve are commonly present. The changes are elicited by tasting and not by chewing. It has been noted that spicy food stimulates the greatest response. Needles[34] stated that this condition occurs most commonly as a sequel to parotitis complicating an infectious disease. In several cases reported in the literature, this syndrome has followed traumatic lesions in the region of the parotid gland. It has occurred following excision of tumors of this gland.

The auriculotemporal nerve delivers both sympathetic and parasympathetic fibers to the parotid gland. Several theories have been presented regarding the etiology of the auriculotemporal syndrome. Some authors concluded that it is an exaggeration of a normally present reflex. Others believed that following injury to the auriculotemporal nerve there is a regeneration of nerve fibers and during this process some of the parasympathetic and sympathetic fibers intended for the parotid gland either grow out into the sweat glands of the skin or anastomose with fibers supplying the sweat glands.

In the opinion of Needles[34] the most likely explanation is that this anomaly arises from the formation of scar tissue resulting from injury in diseases of the parotid gland. When the gland is stimulated into activity, it swells, and pressure is then exerted on the vegetative fibers, which in turn results in vasodilatation and sweating. This author suggested the use of roentgen therapy in the treatment of this entity so that inhibition of parotid activity would relieve the pressure on the nerve fibers.

Summary

The salient features of diseases of the parotid gland are presented, and their treatment is discussed. These various diseases include allergic parotitis, acute inflammation, xerostomia, ptyalism, fistulas, sialolithiasis, parotid tumors, carcinoma and such miscellaneous diseases as mumps, tuberculosis, uveoparotitis, Mikulicz's disease and the auriculotemporal syndrome. The embryology, anatomy and nerve supply of the gland are also briefly reviewed.

Two cases are reported, one of xerostomia and the other of sialolithiasis.

References

1. Fabricant, N. D.: Origin of Some Otolaryngologic Terms, Eye, Ear, Nose & Throat Monthly 29:693-694 (Dec.) 1950.
2. Patten, B. M.: Human Embryology, Philadelphia, The Blakiston Company, 1946.
3. Hansel, F.: Personal communication.
4. Zindler, G. A., and Fraser, R. H.: Allergic Parotid Swelling, J. Michigan M. Soc. 47:863-868 (Aug.) 1948.
5. Waldbott, G. L., and Shea, J. J.: Allergic Parotitis, J. Allergy 18:51-54 (Jan.) 1947.
6. Furstenberg, A. C.: The Parotid Gland; Its Common Disorders, J. A. M. A. 117:1594-1598 (Nov. 8) 1941.
7. Reisman, H. A., and Fischer, G.: Acute Suppurative Parotitis in a Newborn Premature Infant, Am. J. Dis. Child. 71:387-393 (April) 1946.
8. Coller, F. A., and Maddock, W. G.: Water Requirements of Surgical Patients, Ann. Surg. 98:952-960 (Nov.) 1933.
9. Greenbaum, S. S., and Tumen, H. J.: Severe Xerostomia from X-ray Treatment for Hypertrichosis, J. A. M. A. 107:1297 (Oct. 17) 1936.
10. Allington, H. V.: Dryness of the Mouth, Arch. Dermat. & Syph. 62:829-850 (Dec.) 1950.
11. Furstenberg, A. C., and Crosby, E.: Disturbances of the Function of the Salivary Glands, Ann. Otol., Rhin. & Laryng. 54:243-264 (June) 1945.
12. Saphir, W.: Xerostomia Successfully Treated with Nicotinic Acid, Am. J. Digest. Dis. 7:298-299 (July) 1940.
13. Anthony, D. H., and Fisher, D. F.: Diseases of the Salivary Glands and Their Ducts, J. Tennessee M. A. 41:362-378 (Oct.) 1948.
14. Holman, E.: The Treatment of Persistent Parotid Fistulae by Avulsion of the Auriculotemporal Nerve; Report of Two Cases, S. Clin. North America 10:1055-1058 (Oct.) 1930.
15. Portmann, U. V.: The Treatment of Salivary Fistula by Irradiation, Ann. Surg. 101:1175-1180 (May) 1935.
16. Wallace, F. T.: Primary Repair of the Parotid Duct, Am. J. Surg. 70:412-413 (Dec.) 1945.
17. Newman, S. C., and Seabrook, D. B.: Management of Injuries to Stenson's Duct, Ann. Surg. 124:544-556 (Sept.) 1946.
18. Popma, A. M.: Radiation Treatment of Salivary Fistulae, Northwest Med. 40:20 (Jan.) 1941.
19. New, G. B., and Harper, F. R.: Chronic Inflammation of the Salivary Glands with or without Calculi, Surg., Gynec. & Obst. 53:456-460 (Oct.) 1931.
20. Howard, J. M., and others: Parotid Tumors in Children, Surg., Gynec. & Obst. 90:307-319 (March) 1950.
21. Martin, J. D.: Mixed Tumors of the Parotid Gland, New Orleans M. & S. J. 99:99-102 (Sept.) 1946.
22. McFarland, J.: Three Hundred Mixed Tumors of the Salivary Glands of Which Sixty-Nine Recurred, Surg., Gynec. & Obst. 63:457-468 (Oct.) 1936.
23. Buxton, R. W., Maxwell, J. H., and Cooper, D. R.: Tumors of the Parotid Gland, Laryngoscope 59:565-594 (June) 1949.
24. McNealy, R. W., and McCallister, J. W.: Parotid Gland Tumors and Their Surgical Management, J. Internat. Coll. Surgeons 13:523-529 (May) 1950.
25. Clausen, E. G., and Henley, R. B.: The Surgical Treatment of Mixed Tumors of the Parotid Gland, California Med. 68:366-369 (May) 1948.
26. Klopp, C. T., and Winship, T.: Treatment of Mixed Tumors of the Parotid Gland by Subtotal Parotidectomy, Arch. Surg. 61:477-486 (Sept.) 1950.
27. Stein, I., and Geschickter, C. F.: Tumors of the Parotid Gland, Arch. Surg. 28:492-526 (March) 1934.
28. Brown, J. B.; McDowell, F., and Fryer, M. P.: Direct Operative Removal of Benign Mixed Tumors of Anlage Origin in the Parotid Region, with Summary of Parotid Tumors in General, Surg., Gynec. & Obst. 90:257-268 (March) 1950.
29. Jones, C. S., Scarborough, J. E., and Brown, R. L.: Tumors of the Parotid Gland: Review of Seventy-Five Cases, J. M. A. Georgia 38:530-533 (Dec.) 1949.
30. Hersh, J. H.: Primary Tuberculosis of the Parotid Gland Treated with Streptomycin, New York State J. Med. 49:2703 (Nov. 15) 1949.
31. Kirby, W. M. M., and Armstrong, C. D.: Sarcoidosis with Uveoparotid Fever, Ann. Int. Med. 21:475-481 (Sept.) 1944.
32. Anderson, W. A. D., editor: Pathology, St. Louis, C. V. Mosby Company, 1948.
33. Miller, J. R., and Eusterman, G. B.: Mikulicz's Syndrome; Report of a Case with Associated Pulmonary and Gastric Lesions, Proc. Staff Meet., Mayo Clin. 19:425-431 (Aug. 23) 1944.
34. Needles, W.: The Auriculotemporal Syndrome, with Suggestions Regarding Therapy, Arch. Neurol. & Psychiat. 35:357-360 (Feb.) 1936.

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"Periarteritis Nodosa" with Encephalitic Lesions in a Child of Eighteen Months

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We were unable to find a case similar to the one reported in the literature. It is well known that periarteritis nodosa occurs at all ages; at the age of 18 months, however, it is unusual. While many types of vascular lesions may occur,[1] multiple encephalitic lesions with necrosis and gliosis were not noted. Also, lipoid deposits cells[2] occur, but not usually as in this case in lymph nodes, spleen and vascular walls resembling the lipoid dyscrasia, Niemann-Pick disease.

Report of Case

The patient was a first child, born by breach with difficulty and considerable trauma. The birth weight was recorded as 9 pounds 4 ounces, and there was bilateral Erb's palsy with gradual recovery. At the age of 2 weeks there was a somewhat widespread impetigo with generalized lymph adenopathy. At 2 months there was an aural infection, at 8 months mumps and conjunctivitis and at 12 months pronounced cervical adenopathy. During this period there were frequent colds. Development seemed normal the first six months. The child seemed to take no interest in sitting or crawling although he appeared as a rule bright and cheerful. Fever accompanied both colds and teething.

The present illness began with lethargy and fever, which increased to 106 F. at the time of death, six days later.

On physical examination, the child lay quietly, had a stary look and responded only to pain stimuli and movement; the right hand was extended and was not moved as much as the left. There was retinitis pigmentosa, and the right upper lid appeared ptosed. The pharynx was moderately injected. The spleen was enlarged and extended one finger below the umbilicus. The liver was enlarged two fingers below the costal margin. There was great resistance of movement of the muscles of the legs. The neck was slightly stiff, and there was a suggestion of stiffness of the back. There was a moderate Brudzinsky sign and fanning of the toes. There was 3 plus enlargement of the glands on the right side of the neck, 2 plus enlargement of those in the left axillary region and 1 plus enlargement of the right axillary glands. All glands were firm.

The blood count revealed increasing anemia and leukopenia only slightly controlled by transfusions. The urine showed a heavy trace of albumin. In the spinal fluid there was a slight increase in protein, and the heterophil antibody test gave negative results. A bone marrow biopsy was noninformative. A lymph node biopsy showed storage cells taking a fat stain and comparable to those seen in Niemann-Pick disease.

Necropsy Findings.—Positive findings included enlarged lymph nodes with vacuolated deposit cells, edema and congestion of the lungs, and slightly enlarged spleen with groups of storage cells similar to those in the lymph nodes. Most prominent were the vascular lesions present. These were conspicuous in the liver, kidneys, heart, brain, lungs and vessels not associated with organs. It is probable that they would have been found elsewhere with further search. The lesions were of two types; those noted in the brain and those noted elsewhere.

The lesions of the brain were striking because of mononuclear cell infiltrate of Virchow-Robin spaces surrounding necrosis and fresh gliosis. The lesions elsewhere

Fig. 1.— Note the many infarcts of the kidney.

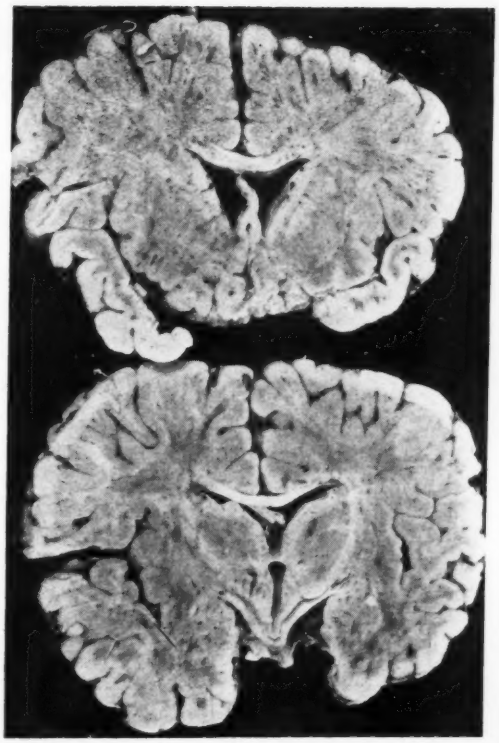

Fig. 2. — Note black accentuated small vascular areas. In these areas one observes microscopically infiltrate of Virchow-Robin spaces with mononuclear cells largely of reticular type and peripheral to this necrosis and early gliosis.

were striking because of deposit cells in the walls of the vessels, cellular infiltrate surrounding the vessels and in the walls, fibrosis, hyaline degeneration ("fibrinoid" collagen) of the walls, thrombosis and organization. The cellular infiltrate showed mononuclears and some polymorphonuclears, but eosinophils were not in evidence. The result of obliteration was in evidence in the infarcts of the kidneys as illustrated in figure 1 and the vascular lesions in figures 2, 3 and 4. The terminal event was congestion, edema of the lungs and early pneumonia. The vascular lesions were accompanied by anoxic lesions in proportion to their occlusion of the areas supplied.

Discussion

A case of periarteritis nodosa is reported because of the unusual manifestations. This name is given because it seems the only category in which to place the collection of manifestations illustrated. The only possible etiologic factor would appear to be the frequent infections. If these were responsible, it must be presumed that this child presented an extremely suitable soil. No outstanding symptom, sign or detail in history would seem to indicate that allergy existed in this case to a greater degree than in cases generally.

Salient features which occur in cases of periarteritis nodosa reported to date are:

1. A basic lesion, arterial, occurring at many sites for reason unexplained; the selectivity of lesions of this type for smaller vessels and capillaries (here with lesions comparable to those described as allergic angiitis[3]); and the frequency of occlusion of end vessels with infarction.
2. The frequency of succession of symptoms at different sites, often with freedom of distress between the attacks.
3. The implication that allergy, therapeutic agents as antibiotics, sulfonamides and thiouracil might be factors.
4. The frequent occurrence of infections as colds and respiratory infections.[4]
5. The frequent reports of eosinophilia as linking with allergy although eosinophils are not necessarily increased or prominent in the lesions; the vascular lesions in eosinophilic granulomas.[5]
6. The production of comparable vascular lesions in laboratory animals.[6]

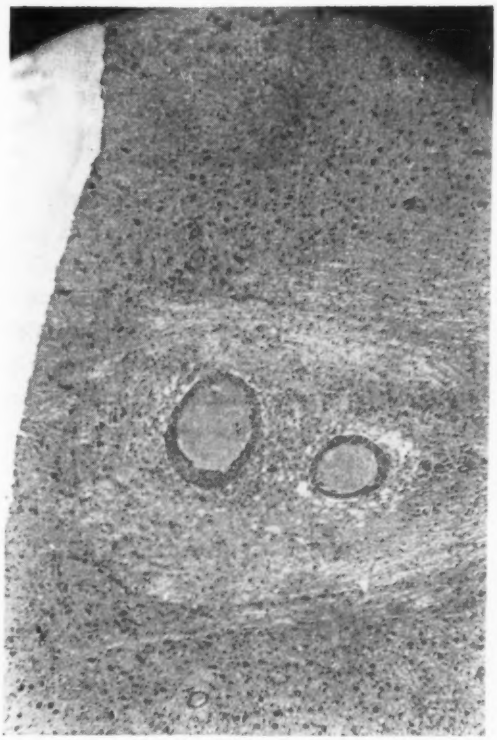

Fig. 3. — Blood vessels of brain. Note infiltrate of cells in Virchow-Robin spaces and distal to this necrosis and early glial response.

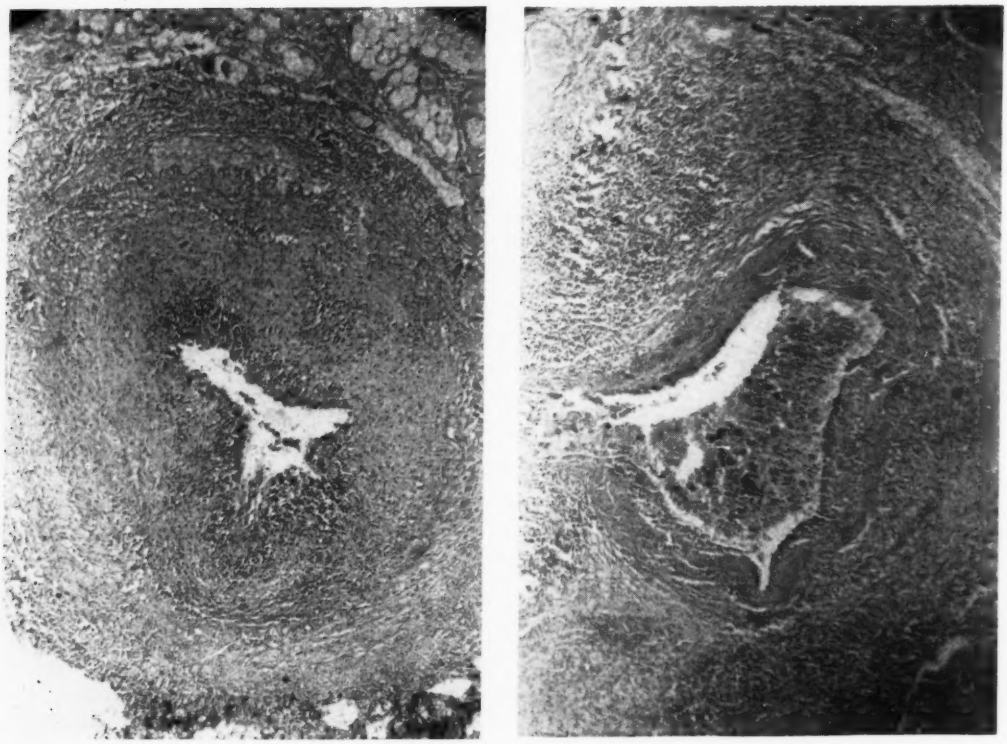

Fig. 4.—Small blood vessels. Left. Artery in neck. Note inflammatory infiltrate of wall, hyalinoid change and deposit cells. Right. Blood vessel of liver. Note hyalinoid change of wall and inflammatory infiltrate about vessel.

Conclusion

An unusual case of periarteritis nodosa is recorded. It is designated periarteritis nodosa since this appears to be the only category in which it can be placed at present. Since the designation periarteritis covers too broad a field, a reclassification would seem advisable when more knowledge of vascular disease is available. Probably a general term angiitis would be best with subclasses.

References

1. Symposium on Periarteritis Nodosa, Proc. Staff Meet., Mayo Clin. 24:17-52 (Jan. 19) 1949.
2. Churg, J., and Strauss, L.: Allergic Granulomatosis, Allergic Angiitis, and Periarteritis Nodosa, Am. J. Path. 27:277-301 (March-April) 1951.
3. Zeek, P. M.; Smith, C. C., and Weeter, J. C.: Studies on Periarteritis Nodosa; Differentiation Between Vascular Lesions of Periarteritis Nodosa and of Hypersensitivity, Am. J. Path. 24:889-917 (July) 1948.
4. Kipkie, G. F., and Johnson, D. S.: Possible Pathogenic Mechanisms Responsible for Human Periarteritis Nodosa, Arch. Path. 51:387-392 (April) 1951.
5. Adams, P., and Kraus, J. E.: Eosinophilic Granuloma, Arch. Dermat. & Syph. 61:957-970 (June) 1950.
6. More, R. H., and Kobernick, S. D.: Arteritis, Carditis, Glomerulonephritis and Bilateral Renal Cortical Necrosis Induced in Rabbits, Arch. Path. 51:361-378 (April) 1951.

Drawer 873.

The Scientific Department of The Journal

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The Enlarged Prostate and Its Surgical Management

S. Joseph Pearlman, M.D.
MIAMI

This presentation will attempt to acquaint the general practitioner with the advances and newer methods that have been developed in the surgical management of the enlarged prostate. Fortified with this knowledge, the family physician will be in a better position to reassure his patient and urge him to seek surgical intervention before the occurrence of serious complications.

Little is known regarding the etiology of this condition despite the numerous studies made. The theory commonly accepted today is that some endocrine imbalance exists between the pituitary and testis.

The enlarged prostate gives rise to signs and symptoms suggesting either irritation or obstruction. The latter may be due to carcinoma, fibrosis, or hyperplasia.

The surgical specimens in the benign enlargements are reported by the pathologist as adenoma, adenofibroma, or fibroadenoma. The term prostatectomy is therefore a misnomer. Adenectomy might be more appropriately used. In order to conform to the standard nomenclature, I employ the term subtotal prostatectomy to distinguish it from the radical total prostatectomy for carcinoma, in which the entire prostate, including the true, false, and surgical capsules, is removed.

Preoperative Survey

Present day urologists are reluctant and find it unnecessary to rush a patient into the operating room for surgery without knowing anything of the patient's physical status. The preoperative work-up, which is as important as the operative procedure itself, can be carried out at the office or hospital, depending upon whether the patient presents himself in chronic or acute urinary retention. The following information is deemed essential:

1. A complete urinalysis, to include culture and a Gram stain.
2. An estimation of the residual urine.
3. A complete physical examination.
4. A rectal examination to determine the size, shape, consistency and fixity of the prostate. A gentle massage of the prostate is made, and the expression is examined for pus, blood and organisms.
5. Excretion urography to outline the upper part of the urinary tract.
6. The lower portion of the urinary tract is outlined by means of cystograms, aerograms and cystourethrograms.
7. A two hour intravenous phenolsulfonphthalein test is then made, with plotting of the curve of excretion at fifteen minute intervals.
8. Blood chemistry determinations are then made to include nonprotein nitrogen, sugar, chlorides, and serum acid phosphatase.
9. An electrocardiogram, cardiac evaluation, and a roentgenogram of the chest are then obtained.
10. Cystoscopy should not be necessary unless to clear up some doubtful point in the history or physical examination, but, if indicated, it should be done at the hospital, preferably after an anesthetic has been administered.

In acute urinary retention, when the patient is about 50 years of age, obstruction of the neck of the bladder, usually an enlarged prostate, should be suspected. In younger persons, stricture of the urethra, a sequela of an old gonorrheal infection, is usually the cause. To relieve the patient in acute retention a Fr. 14 or 16 Foley catheter is used and left indwelling, withdrawing the contents of the bladder gradually. Occasionally catheteri-

Read before the staff of the Edgewater Hospital, Miami, May 15, 1951.

zation may be difficult or even impossible. Trocar cystostomy then becomes imperative and can be done through a small incision under local anesthesia, with introduction of a small Foley catheter through the trocar. This procedure is innocuous compared to a difficult catheterization except, however, in cases in which operations have previously been performed in the suprapubic region.

When the symptoms of frequency, nocturia, urgency, and difficulty in urination are more pronounced and the residual urine measures 2 ounces or more, operative intervention is indicated. The enlarged gland felt by the examining finger in the rectum is graded from 1 to 4 depending upon the degree of protrusion. The gland is also graded from 1 to 4 when the extent of intrusion into the urethra or bladder is viewed through the urethroscope.

Methods of Removal

Four methods are employed today in the removal of the enlarged prostate. These are suprapubic, perineal, transurethral and retropubic prostatectomy. The advantages and disadvantages of each procedure are presented.

The suprapubic prostatectomy is the easiest to learn and to perform, and often with a patient whose physical condition is below par, a two stage procedure becomes necessary. The enucleation is a blind procedure, and reconstruction of the neck of the bladder is difficult. The one stage procedure in the patient who is in better physical condition is accompanied by more shock and greater loss of blood. A portion of the vas deferens on each side is excised between two ligatures through small scrotal incisions as a prophylactic against postoperative epididymitis. This procedure is carried out with all four methods of prostatectomy.

Perineal prostatectomy is an excellent operation in the hands of surgeons trained in this method. It is a one stage procedure, and there is a relatively smooth postoperative course. This operation is most frequently followed by sexual impotence, and often closure of the fistula takes a long time. Urinary incontinence frequently follows the radical operation and occasionally occurs in the benign subtotal prostatectomy. The dressings are messy because the incision is just above the anus.

Transurethral prostatectomy is the most difficult to learn and to perform, and even the most experienced resectionists advise against attempting to remove the gland with grade 4 enlargement by this method but will tackle the gland with enlargement ranging from grade 1 to grade 3. The complications with this procedure are:

1. Hemorrhage, which is often severe and can cause exsanguination in a few hours. Late hemorrhage may occur in four to five days, often ten to twelve days, and occasionally two to three weeks. This is usually due to sloughing of infected tissue or extensive coagulation.
2. Infection for prostatitis is practically always associated with hyperplasia and may add to the symptoms of frequency and urgency. The retention catheter also promotes infection, and especially so when the residual urine is infected.
3. Incontinence frequently follows this procedure and is due to direct injury to the external sphincter when the resection is carried too far distally in front of the verumontanum. Damage to the external sphincter may also be caused by overdilatation of the urethra by the large caliber resectoscope employed, or from traction with the Foley catheter.
4. Hemolysis is a serious complication, terminating fatally in many cases. The irrigating fluid enters the general circulation through the venous sinuses in the prostatic capsule, or through the open veins in the prostatic bed. This produces hemoglobinemia and the kidney of shock described as lower nephron nephrosis.
5. Perforations of the bladder frequently occur, necessitating immediate suprapubic cystostomy.
6. Perforations into the rectum are common, resulting in rectourethral fistulae.
7. Strictures of the urethra are common sequelae.
8. Explosions within the bladder by accumulated gases have proved fatal in a few cases. Because of these complications many urologists now restrict this procedure to cases presenting the following lesions: carcinoma, median bar formations, contracture of the vesical neck, middle lobe and grade 1 and 2 enlargements.

In 1947, Terrence Millin, of London, England, introduced into this country a new approach, the retropubic prostatectomy. This operation has

been received enthusiastically by urologists throughout the country. Its advantages lie in its direct approach to the prostate. The enucleation is carried out without opening the bladder. Hemorrhage can be controlled before incising the capsule. Large vessels on the surface can be seen and ligated. There is no danger of incontinence. Radical excisions can be carried out with this method when biopsy demonstrates carcinoma. The postoperative course is remarkably smooth, and in my series of cases, totaling 40, the patients have been discharged on the fifth postoperative day with a closed and dry wound. Complications with this method are few in number. Periosteitis pubis has been reported, but the incidence of this complication is now decreasing as urologists become more familiar with the operative technic. This complication, I believe, can be avoided if care is taken not to traumatize the periosteum when closing the prostatic capsule. Occasionally a fistula will result, but this can be corrected by reinserting a Foley catheter for an additional two to three days.

Summary

Better results in prostatic surgery are obtained when the patients seek medical aid early and when the preoperative survey is thorough.

The advantages and disadvantages of the four operative methods are discussed.

In my opinion, based on a series of 40 cases, retropubic prostatectomy will become more popular as urologists familiarize themselves with the technic and carry out the indicated procedures faithfully.

References

1. Millin, T.: Retropubic Urinary Surgery, Baltimore, Williams & Wilkins Company, 1947.
2. Rolnick, H. C.: The Practice of Urology, Philadelphia, J. B. Lippincott Company, 1949.

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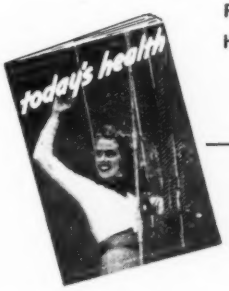

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This May Journal carries the new officers and committeemen with the exception of the president-elect, vice presidents, secretary-treasurer and editor of The Journal. The names of these officers are omitted because the May Journal went to press before the election of officers by the House of Delegates, April 30.

All new officers will be listed in your June Journal, as will the personnel of The Journal staff for 1952.

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James R. Boulware, Jr., M.D. ..... Lakeland
Herschel G. Cole, M.D. ..... Tampa
Wilson T. Sowder, M.D. ..... Jacksonville
Carlos P. Lamar, M.D. ..... Miami
Walter C. Payne, M.D. ..... Pensacola

Managing Editor
Stewart G. Thompson, D.P.H.

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Chas. J. Collins, M.D. ..... Orlando
James N. Patterson, M.D. ..... Tampa

Abstract Department

Kenneth A. Morris, M.D., Chairman ..... Jacksonville
Walter C. Jones, M.D. ..... Miami

NOTICE

This May Journal carries the new officers and committeemen with the exception of the president-elect, vice presidents, secretary-treasurer and editor of The Journal. The names of these officers are omitted because the May Journal went to press before the election of officers by the House of Delegates, April 30.

All new officers will be listed in your June Journal, as will the personnel of The Journal staff for 1952.

Gifts to A. M. E. Foundation

The undersigned attended an all day conference in Chicago, February 17. This conference was the 1952 "kick-off" for the American Medical Education Foundation. Representatives from almost every state medical association were present and your correspondent attended because Dr. Julius C. Davis, chairman of our Committee on Medical Education and Hospitals, was unable to attend. The writer will assume the chairmanship of this committee April 30.

This meeting was most informative and inspiring and important plans were formulated for 1952. Presiding was Dr. Elmer Henderson, president of the American Medical Education Foundation. The history of the Foundation and the results of the work in 1951 were described by Dr. Donald Anderson, secretary-treasurer of the Foundation. An outstanding expert in fund raising, Dr. James Almond, president of the American City Bureau of Chicago, addressed the group. This was followed by a session called "Much to Do in 52" in which the goal, the plan and the mechanics of raising funds for the Foundation were discussed at length.

This meeting impressed the writer anew with the importance of each of us in the Florida Medical Association contributing to the American Medical Education Foundation.

Jack Q. Cleveland, M.D.

Medical Education Fund Campaign

Placing emphasis at the grass roots level, the 1952 campaign of the American Medical Education Foundation for funds for the nation's medical schools now enters the second month of intensive solicitation of the medical profession, scheduled during the period April 1 through June 30. Each state society is charged with the responsibility of conducting its own campaign by methods it knows best, since the individual society is in the best position to judge the type of campaign likely to be most effective among its membership.

Two million dollars is the minimum goal set by the Foundation for this year, "with the realistic figure being near four million." Token gifts will by no means raise such a sum. If leaders at the state and county levels approach the members of the profession individually as well as through mass mediums, a sufficient number of physicians undoubtedly will contribute generously enough to assure this goal from this source alone. Help is

always needed at the local level, especially in a project of this magnitude and importance, and it is believed that members of the Florida Medical Association, along with their colleagues of other state associations, are sufficiently interested in solving their own problems to volunteer to give the necessary time and money so that this worthy undertaking may be crowned speedily with success.

At the initial meeting launching the drive, Dr. James E. Almond of Chicago declared: "It can be said without the slightest fear of contradiction that 1952 will see the greatest total contribution to voluntary philanthropy in our country's history . . . and this stream of dollars will increase in volume with steady annual increment for a long time to come." This outstanding pioneer in the fund-raising field added: "The penalties of leadership cannot compare with its privileges. The men who are taking the initiative in this crusade will have their achievements recognized through the ministry of higher education for generations to come." Who within the Association would deny himself the privilege of participating? Surely, not a single member.

Science Versus Sentiment

It was with particular interest that the editorial eye fell recently upon an article[1] suggesting that the "various medical journals need to give more space and greater expression to sentiment, certainly those at least which are not limited in purpose to the furtherance of pure science." Deploring the present imbalance between science and sentiment, the author thought it justifiable for "medical journals to reprint on occasion the best from Osler, Holmes, Barrett, Sir Thomas Browne, and that stirring tale of the doctor of 'the auld school' found in 'The Bonnie Briar Bush.'" The suggestion is refreshing.

Medicine truly "bespeaks a universal language of the heart." In its transition from a practice largely an art to one predominantly a science, it undoubtedly has sacrificed certain of its essentials. These factors inherent in its traditional influence need to be revived.

Perhaps the major one is sufficiency of time, as this article suggested. It does indeed require a sufficiency of time to sound the soul of man, to listen to those who are sick at heart, to take a personal, intimate interest in each individual patient. A packed appointment book of course precludes the fulfilment of this concept. The overworked physician agrees readily with Omar Khayyam that "the bird of time has but a little way to flutter and, lo, the bird is on the wing." Yet the aim of medicine is to render man physically fit and mentally happy.

Inspired leadership within the profession is another priceless component which needs reviving. Science appears to be crowding out sentiment in medical schools. "Too early and too much does the student learn about the miracle drugs. Less often, if at all, is he embued with the faith and philosophy of the great men of medicine who made medicine great." There is likewise opportunity for inspired leadership in the contacts with younger practicing physicians, and, too, with older ones who are inclined to relinquish the human touch for neoscience.

Who will deny that the primary requisites of a good physician are sympathy and understanding of human problems and the travail of the human heart? Such a physician fulfils his obligations to society only in so far as he appreciates that for his patients a full life is measured not by length alone but also by depth and breadth.

Leaving this country in 1905 to teach at Oxford, Sir William Osler reminded his American colleagues in these words of a noble tradition attributed to the profession by all mankind half a century ago: "Medicine is the only world-wide profession actuated by the same ambitions and pursuing the same ends. . . . A united profession working in many lands has done more for the race than any other body of men." Such a heritage is to be cherished; such influence is to be perpetuated. Righting the imbalance between science and sentiment may well be carrying on in the best tradition.

1. Johnstone, R. T.: Medicine Can Bridge the Sullen Tide, J. A. M. A. 147:911-913 (Nov. 3) 1951.

The Physician of Tomorrow

The slow but progressive evolution of medical intelligence has brought medical thought through successive steps from the hazy horizon of antiquity to the bright light of today, made brighter by tremendous strides in the kindred sciences of chemistry and physics. During the last two centuries, the tendency to study the disease to the exclusion of its host — man, himself — has gradually but constantly developed. With all of the profound changes of the past two decades alone in the practice of medicine, with all of the brilliant contributions of science, there nevertheless appear signs

that the pendulum has begun to swing to a more balanced position. A timely return to a modification of the Hippocratic tendency to view man as a whole, as well as his disease, appears under way.

It has been aptly said that the physician of tomorrow must view disease with the telescope as well as with the microscope. Biologic, sociologic and psychologic influences must take their place beside the bacteriologic and pathologic factors. Medicine has a vital role in reviving a sick society. The social scientists almost uniformly believe that present day conflict between groups and nations results largely from years of cumulative mental immaturity, that for too long men of immature mind have held high office. But they — the psychologist, the sociologist and the cultural anthropologist — think in terms of the group and advocate suitable group disciplines.

The physician, on the other hand, endowed with the means of preventing or curing disease, has the truly grass roots approach to the social problem for he has a peculiar opportunity to help the individual adjust himself to his environment. He is privileged to start at the beginning — with the individual and his family, the smallest unit of society. With the training to resolve psychosomatic problems, he can aid incalculably an ailing society through the basic step of implanting love, harmony and peace of mind within the family.

In the light of the present trend, the future physician will be versed in the humanities as well as the sciences. His success in the science of medicine will parallel his appreciation of its art. Without deviating from the scientific attitude, he will temper the use of his array of scientific facts with a sincere attempt to evaluate their effect on man — the Personality. To a broader, more effective use of these facts than his colleagues of today command, he will add a more comprehensive understanding of the intricate processes which make up the personality of man. As he comes to appreciate the totality of conditions, internal and external, as he takes due cognizance of the varying influences of the manifold reactions in the soil which harbors disease, the essential principle of viewing disease not apart from but with man will triumph, as it should. May he be ever mindful of Hippocrates' wise observation that where there is love of man there is also love of the art of medicine.

Successful Diabetes Seminar

A Seminar on Diabetes Mellitus, presented by the Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association, the Florida State Board of Health and the Palm Beach County Medical Society, was held in West Palm Beach, March 27-28, 1952. Dr. Howard Root and Dr. Priscilla White of Boston together with Dr. Johen W. Runyan, Jr., of the United States Public Health Service and Dr. Edward R. Smith of the State Board of Health delivered stimulating lectures, which were particularly well received. Much of the material covered by Dr. Root and Dr. White is incorporated in their new book soon to be published.

The registration for the meeting totaled 81. At a meeting for the public on Thursday night, March 27, there were approximately 350 in attendance.

Twentieth Annual Graduate Short Course June 23-28, 1952

The Twentieth Annual Graduate Short Course will be held at the George Washington Hotel in Jacksonville, June 23-28, 1952. The faculty is as follows:

Medicine: Dr. George S. Mirick, Associate Professor of Medicine, The Johns Hopkins University School of Medicine, Baltimore.

Surgery: Dr. Howard Mahorner, Clinical Associate Professor of Surgery, Louisiana State School of Medicine; Director, Mahorner Clinic, New Orleans.

Pediatrics: Dr. Jay M. Arena, Associate Professor of Pediatrics, Duke University School of Medicine, Durham, N. C.

Obstetrics: Dr. M. Edward Davis, The Joseph Bolivar DeLee Professor of Obstetrics and Gynecology, University of Chicago and the Chicago Lying-in Hospital, Chicago.

Gynecology: Dr. Andrew A. Marchetti, Professor and Chairman of the Department of Obstetrics and Gynecology, Georgetown University School of Medicine, Washington, D. C.

Diseases of the Chest: Dr. H. McLeod Riggins, Associate Clinical Professor of Medicine, College of Physicians and Surgeons, Columbia University, New York.

SCHEDULE FOR SHORT COURSE

HOUR	Monday June 23	Tuesday June 24	Wednesday June 25	Thursday June 26	Friday June 27	Saturday June 28
8:00	**Registration**					
9:00	**Diseases of the Chest** "Recent Advances in, and Basic Concepts of Prolonged Chemotherapy and Resection Surgery for Pulmonary Tuberculosis" Dr. Riggins	**Pediatrics** "Cancer in Childhood" Dr. Arena	**Pediatrics** "Congenital Pyloric Stenosis" Dr. Arena	**Obstetrics** "The Management of the Placental Stage and Postpartum Hemorrhage" Dr. Davis	**Gynecology** "Pelvic Inflammatory Disease" Dr. Marchetti	**Gynecology** "Adenocarcinoma of the Body of the Uterus" Dr. Marchetti
10:00	**Pediatrics** "Accidental Poisoning in Children" Dr. Arena	**Diseases of the Chest** "Some Practical Problems in the Diagnosis and Treatment of Miscellaneous Nontuberculosis Chest Diseases" Dr. Riggins	**Medicine** "Infectious Hepatitis—Clinical Studies" Dr. Mirick	**Gynecology** "Endometriosis and Adenomyosis" Dr. Marchetti	**Obstetrics** "Sterility Investigation" Dr. Davis	**Surgery** "Surgical Lesions of the Neck, Including Goiter" Dr. Mahorner
11:00	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**
11:30	**Medicine** "Primary Atypical Pneumonia" Dr. Mirick	**Pediatrics** "Immunization and Prophylaxis" Dr. Arena	**Obstetrics** "Modern Prenatal Care" Dr. Davis	**Surgery** "Surgical Lesions of the Colon and Rectum" Dr. Mahorner	**Surgery** "A. The Differential Diagnosis of Peripheral Vascular Disturbances B. Their Surgical Treatment" Dr. Mahorner	**Gynecology** "Ectopic Pregnancy" Dr. Marchetti **Surgery** "Experiences with Gastric Surgery" Dr. Mahorner
12:30	**Lunch**	**Lunch**	**Lunch**	**Lunch**	**Lunch**	
2:00	**Pediatrics** "Rheumatic Fever" Dr. Arena	**Medicine** "The Uses and Abuses of Antibiotics" Dr. Mirick	**Medicine** "Infectious Hepatitis—Experimental Studies" Dr. Mirick	**Obstetrics** "The Conduct of Abnormal Labor" Dr. Davis	**Obstetrics** "The Diagnosis and Treatment of Bleeding in Late Pregnancy" Dr. Davis	
3:00	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**	
3:15	**Medicine** "Drug Resistance of Micro-organisms" Dr. Mirick	**Diseases of the Chest** Subject to be announced Dr. Riggins	**Pediatrics** "Hemolytic Anemias in Childhood" Dr. Arena	**Surgery** "A. Varicose Veins B. Thrombosis and Postthrombophlebitic States" Dr. Mahorner	**Surgery** "Surgery of the Bilary Tract" Dr. Mahorner	
4:15	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**	
4:30	**Disease of the Chest** "The Diagnosis and Present Medical and Surgical Treatment of Acute and Chronic Suppurative Pulmonary Diseases" Dr. Riggins	**Medicine** "The Adrenal Steriods and Infection" Dr. Mirick	**Obstetrics** "The Management of Abortions" Dr. Davis	**Gynecology** "Abnormal Uterine Bleeding" Dr. Marchetti	**Gynecology** "Gynecologic Conditions Complicating Pregnancy" Dr. Marchetti	

State Fair Exhibit

The fact that the American public spends about 24.6 billion dollars a year for such things as tobacco, alcohol, toilet articles and recreation as compared with 7.9 billion for medical care was forcefully brought to the attention of thousands of visitors who attended the Florida State Fair Feb. 5-16 at Tampa.

This was accomplished by the first Fair Exhibit ever sponsored by the Florida Medical Association — an exhibit which combined color, humor and action to effectively tell its story.

The exhibit, occupying a 45 foot center space in the Pan-American Building, was manned by a staff of 22 technicians, 48 student nurses and 58 members of the Woman's Auxiliary to the Hillsborough County Medical Association, to provide free blood grouping and typing and blood pressure determinations to the public. Members of the staff of the Association's Bureau of Public Relations were in continuous attendance from the opening day until the Fair closed.

During the 11 day run of the Fair, 11,470 persons took advantage of this service — 7,630 having had their blood pressure checked and 3,840 being recorded as having their blood typed. The results of the tests were given to the applicants on pocket-size cards on which was printed "Courtesy of the Florida Medical Association." In addition, more than 15,000 pieces of medical literature, stamped with the Association's name, were distributed.

Blood pressure and typing activities terminated each day at 8 p.m. From that hour interest centered on the exhibit. Square white bases, topped with revolving gold colored stacks of coins, heightened with humorous cut-out figures, made people stop to look. They saw the long gold-on-green sign "Sponsored by the Florida Medical Association" and then the smaller signs in the same colors that gave the essence of the story: drugs $1.4 billion, hospital care $1.8 billion, physicians' services $2.3 billion, all other medical care $2.4 billion and the total $7.9 billion. Then was shown the money spent for pleasure: toilet articles $2.2 billion, tobacco $4.3 billion, alcohol $7.9 billion, recreation $10.2 billion — a total of $24.6 billion. These figures were taken from U. S. Department of Commerce estimates for 1949.

Many people stopped and jotted down these figures. Others remarked: "I didn't know we were having that big a time, and paying so little to keep in condition to have it."

For those who could not attend the Fair, the local daily newspapers, a radio station and the wire services took the story to them. Scarcely a day passed during the Fair that some mention of the exhibit was not carried in the paper. Several feature stories, with photographs, were also published. For a Sunday afternoon radio program, a station featured the electrical show and the Florida Medical Association's display. Preceding opening of the Fair, the major dailies in the state carried a coupon which would entitle the bearer to a free blood pressure check.

Blood grouping and typing was under the direction of Dr. James N. Patterson, assisted by Dr. Wray D. Storey, both of Tampa. Mound Park Hospital School of Nursing, St. Petersburg, and the Gordon Keller School of Nursing, Tampa Municipal Hospital, provided student nurses for taking blood pressures. The Southwest Florida Blood Bank, Tampa Municipal Hospital and the private laboratory of Drs. Herbert R. Mills and James N. Patterson, Tampa, furnished technicians for grouping and typing.

Idea for the Fair exhibit was first conceived by President David R. Murphey, Jr., and Dr. Eugene B. Maxwell, chairman, Committee on Public Relations, both of Tampa. Dr. Maxwell briefly discussed the exhibit plan before a meeting of his committee at Hollywood during the 1951 convention of the Association. It was further elaborated upon and explained by Dr. Maxwell at each of the medical district meetings in October. The idea had the unanimous approval of the Board of Governors of the Florida Medical Association.

In November Dr. Murphey called together physicians, newspapermen, cartoonists, artists and exhibit makers to discuss what could be done. The group agreed to use an idea which appeared originally as a cartoon in *Medical Economics*. It was decided that the story told by the cartoon — the comparative cost of medical care — could be sharpened, and that the theme itself could be broadened by adding four original cartoons to the exhibit. These drawings would be mounted on the exhibit's base and lighted from the back to make them clear.

Byron Stephens, an artist on the staff of the Tampa *Tribune*, was made general supervisor in charge of building the exhibit. He was requested to prepare a working sketch. George White, a cartoonist, was asked to prepare the four drawings. After Mr. Stephen's sketch had been approved by the Board of Governors, the contract for construc-

ion was awarded. On Jan. 27, 1952, a week before the Fair was to be opened, the exhibit was ready for a preview.

In the meantime Dr. Murphey and Dr. Maxwell made arrangements with members of the Woman's Auxiliary to the Hillsborough County Medical Association to be on duty at the exhibit. They also arranged for Mound Park and Gordon Keller to furnish student nurses. This gave these training schools the opportunity to contact many prospective students.

During the 11 day showing, the exhibit had a host of compliments — from Fair officials, both local and out of state, from educators, from the average man and from physicians.

One Auxiliary member summed up all their reactions: "This is the most appreciative crowd I have ever seen."

* * *

After the close of the Fair, the following night letter was received from Mr. Lawrence W. Rember, Field Director of the American Medical Association Department of Public Relations. Mr. Rember recently was in Florida for a week. He spent his first two days at the Association's office in Jacksonville where he conferred with department heads. He then proceeded to the State Fair at Tampa where he had opportunity to make first hand observations of the effectiveness of the exhibit.

1952 March 27, A. M. 1:26

Dr. David R. Murphey, Jr., President
Florida Medical Association
442 West Lafayette Street
Tampa, Florida

Your medical exhibit at the Florida State Fair had everything that makes a public exhibit successful. It had action and color. It was dignified in its message and in its green, gold and white attire. Every part of it was truly worthy of the ethical and honored profession which it represented. Yet it possessed that vital quality of getting through to the mind and emotions of the common man — who made up the vast majority of that 1,000,000 plus men and women who went through the turnstiles of the Fair.

The revolving piles of money; the identifying cutouts on the top of them; the added eye-catcher cartoons dramatizing medicine's progress; the nearness of the modern doctor; the benefits of health insurance; and the drug miracles of private enterprise; the compelling facts contrasting how much less people

Association Exhibit — Florida State Fair, Tampa, Feb. 5-16

pay for health services than they do for personal pleasure; the strategic location; the lighted ribbon "Medical Information" ceiling signs; the audience participation; the facilities for sitting and absorbing the message; the clockwork precision and the highest type of personnel manning the blood pressure and blood typing tables all attest to the thoroughness, the creativeness, the professionalness, the inevitable effectiveness of the exhibit.

Is it any wonder that the word got around that it was "the hottest thing at the Fair."

One basic human motivation often makes an exhibit highly successful. You tossed everything at them in the persuasion book. You appealed to curiosity, self preservation, the desire to get something free (acquisitiveness). You achieved the ultimate in publicity — in maintaining the flow of customers and enlarging their numbers by the band wagon device — by such mechanisms as snaring Hal Boyle, famed feature writer of the Associated Press, and U. S. Senator George Smathers, and spreading their approval and their appeal through pictures and through words in the daily press.

For the first time many Floridians and out-of-state guests gained a new, positive association between the public welfare and the medical profession of your state. The exhibit rendered a real service to the more than 11,000 people who had their blood typed and pressured. The record cards given out will serve as a personal reminder in women's purses and men's billfolds for months and even years to come of the free favor rendered by the doctors of Florida. They will also long remember the dramatized truth on medical care costs versus other expenditures and how favorable to the Florida citizen's pocketbook the purchase of medical care is.

Judge and maid alike came through the line and walked a common medical good will path.

When you told me that the literature you were passing out at the exhibit could not be found anywhere discarded on the Fair grounds, I had to see it with my own eyes to believe it. So on Saturday I did. I found . . . [from various organizations] . . . folders and pamphlets scattered about on the floors in Fair buildings and on the open Fair grounds. But I did not find one piece of tossed away medical literature. I knew then what the mother meant when she said to the child who picked up the literature which had just been handed to her at the end of the blood typing table: "Lay that down; mama has to read that."

Yes, it's to your credit that so many thousands of folks got something from the medical people while they were attending the State Fair of which they are proud and which to many of them is an important experience in their lives.

It can be said in truth that in no State Fair in the United States to my nationwide knowledge has a medical exhibit attained such heights of public appeal or obtained so much good will for the doctors and the medical profession as did the medical exhibit designed and sponsored by the Florida Medical Association.

It was a privilege and an education to be present. I shall carry word of it throughout the land for the benefit of other societies.

Larry Rember

Progress in Emergency Call Programs

Provision for emergency medical treatment poses a primary problem for the medical society. While emergencies are few in number compared to all other medical care services, their inherent possibilities for unfavorable criticism are not to be ignored. The reputation of the whole profession suffers when the layman, unable to obtain the services of a physician whenever he needs them, complains that physicians are not serving the public properly. His argument carries the same weight even though a physician may have been available, but he did not know how to contact him. An important project for any medical society, therefore, is the development of an efficient emergency call plan as a means of assuring the public that medical care will be available when needed.

It is gratifying to note the rapid strides made recently in developing emergency call systems. In 1948, approximately 60 medical societies reported having a formal plan for handling emergency and night calls; the estimated number in 1949 was between 100 and 120; and in 1950 it had risen to more than 350. Among 364 medical societies reporting emergency call plans to the American Medical Association Committee on Medical Service,[1] over 80 per cent of the large societies, with 200 and more members, now have emergency call plans. Slightly less than half, however, of the societies whose membership ranges from 100 to 200, and only 13 per cent of those with less than 100 members, have such a plan.

There is obviously need for more work on the problem, especially among the smaller medical societies. To learn the various methods employed in handling the plans, the Council on Medical Service recently surveyed the emergency call methods employed by 143 county medical societies, the majority of them in the smaller societies. The information is now available for the medical society officers at the Council office and is being prepared in pamphlet form designed particularly for county medical societies.

Local conditions determine the type of plan. The central dispatching office may be a hospital a private telephone service or a society owned and operated telephone service. In some communities the regular physician-patient relationship suffices for emergencies. Whatever the plan, the definite function of the medical societies is to make sure that no emergency call goes unanswered. Not only should they provide for unity and direction of indi-

vidual physician effort, but they should also publicize the program widely and continuously to keep the public aware of it and how it should be used. At the outset, it should be made clear that the plan is for use only when actually necessary. To be successful, emergency call plans require the cooperation of the public as well as of physicians and their medical societies.

1. Emergency Medical Call Programs. Council on Medical Service. J. A. M. A. 148:491-492 (Feb. 9) 1952.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Aten, William G., Jr., Miami
Bechtel, Jack T., Eau Gallie
Bielek, Miles J., Fort Lauderdale
Blades, James E., Nokomis
Brownlee, Harry G., Zephyrhills
Clifford, William J., North Miami
Cole, J. P., Tampa
Crosby, William R., Tampa
Derrick, Walter A., Orlando
Dunton, Loren A., DeLand
Edwards, Joshua L., Durham, N. C.
Hege, John R., Jr., Hollywood
Ingram, J. M., Jr., Tampa
Jensen, Edwin J., Miami
Johnston, Harold W., Orlando
Juers, Arthur L., Miami
Kay, John H., Panama City
Kelley, Edmund P., Sarasota
Knight, Victor H., Jr., Tampa
Marsh, John G., Orlando
Milloff, Bernard, Hollywood
Neill, James M., St. Petersburg
Polk, Rothwell C., Jacksonville
Sheehan, Frank T., Miami
Tobin, Walter R., Miami
Vaughn, James A., Jr., South Miami
Wallace, Thomas H., Sarasota
Wells, Carl H., Jacksonville
Zick, Luther H., Tampa

YOUR BLUE SHIELD

Blue Shield Liaison Committees

One of the things that is to be developed from the "Physician's Personal and Professional Data Sheet" recently circulated by the Florida Blue Shield Plan will be the development of liaison committees in the county medical societies. Similar committees are working very satisfactorily in other parts of the country and do an excellent job in bringing the Plan and the Doctor closer together. The fine cooperation that has been experienced by the Plan in the past leads the Plan to believe that the committee will be very successful here in Florida. These committees, when set up by the society presidents, will form a nucleus of Blue Shield information and will be close at hand for the doctors in each community. Some societies have already appointed their liaison committees, and in the not too distant future, further steps toward a working arrangement will be made.

Should you desire more information on these committees, contact the Florida Blue Shield Plan in Jacksonville at Post Office Box 1798.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Harold Rand of Miami announce the birth of a daughter, Jennifer May.

Dr. and Mrs. Jackson L. Allgood, Jr., of Jacksonville announce the birth of a daughter on March 8.

Dr. and Mrs. Samuel M. Day of Jacksonville announce the birth of a son, Arthur Lennard, on April 9.

Deaths — Members

Thomson, Wm. R., Miami ..... March 17, 1952
Perdue, J. Randolph, Miami ..... March 27, 1952

Deaths — Other Doctors

Burkett, Wyatt T., Dothan, Ala. ..... October, 1951
Williams, Lois F. D., Fort Pierce ..... Nov. 18, 1951
Dux, Henry M., Jacksonville ..... March 18, 1952

STATE NEWS ITEMS

The second annual seminar on recent advances in diagnosis and treatment, sponsored by the Mount Sinai Hospital of Greater Miami, will be held May 22-24 at the Delano Hotel, Miami Beach.

Eight outstanding lecturers from leading medical schools throughout the nation will conduct the seminar. Subjects to be presented include gastro-intestinal diseases, diabetes, hematology, surgery, thyroidology and electrolyte disturbances.

Invitation is extended by the Seminar Committee to all Florida physicians. Registration is $20 with attendance at the banquet optional. Interns and residents will not be required to pay a registration fee.

For additional information contact Dr. Jandon Schwarz, Mount Sinai Hospital of Greater Miami, 4300 Alton Road, Miami Beach 40.

Dr. Arthur J. Butt of Pensacola recently gave a series of lectures on the "Management of Renal Lithiasis," at the Los Angeles Postgraduate Medical Assembly.

Drs. Earl R. Templeton of Miami Beach and DeWitt C. Daughtry of Miami were among a group of physicians making a tour under the sponsorship of the World Medical Association to bring the latest medical technics and developments to physicians in Cuba, the Dominican Republic, Venezuela and Panama.

Dr. Merritt R. Clements of Tallahassee addressed a recent meeting of naval reservists at Dale Mabry Field. Dr. Clements, a Lieutenant Commander in the naval reserve, spoke on "The Navy Doctor."

Drs. J. Brown Farrior and Richard A. Bagby of Tampa have been awarded accreditative diplomas for their exhibit on ear surgery at the third Pan-American Congress of Otolaryngology in Havana, Cuba, during January. Their exhibit was given second award in the scientific exhibit at the meeting.

Dr. James C. White of West Palm Beach spoke on heart disease, its treatment and the present research by the American Heart Association, at a local Business and Professional Women's Club meeting in February.

Drs. John F. Lovejoy, George I. Raybin and Eugene M. Frame of Jacksonville were among the physicians attending the sixteenth annual Crippled Children's Clinic, sponsored by Haisley Lynch Post 16, American Legion and Auxiliary, in Gainesville. The clinic is held in Gainesville each year by the Florida Crippled Children's Commission and is for all children in the county.

Dr. Morris H. Blau of Miami, representing the Dade County Medical Association, spoke at a recent meeting of Roosevelt Temple 33, Pythian Sisters, of that city. A movie on cancer was also shown.

Dr. David R. Murphey, Jr., of Tampa, president of the Association, spoke at a meeting of the Rotary Club of Dunedin on March 4. Dr. Murphey, who was introduced by Dr. Harold E. Winchester of Dunedin, traced the course of medical history in America from its feeble beginning to the present.

Four members of the Dade County Medical Association described medical services available to Dade County residents at a recent meeting of the Dade County Health Council. They were Drs. John D. Milton, president of the Medical Service Bureau; Ralph W. Jack, president-elect of the Dade County Medical Association; Willy M. Sams, chairman of the County Medical Association's grievance committee; and Richard [illegible]. Stover, chairman of the public health advisory committee.

Drs. Henry L. Harrell of Ocala and Walter W. Sackett, Jr., of Miami attended, as official representatives from Florida, the Annual Convention of the American Academy of General Practice at Atlantic City, March 23-27.

A Crossroads Cancer Seminar is being sponsored by the American Cancer Society, Florida Division, the Florida State Board of Health, the County Medical Societies and the health departments in the counties concerned. Meetings will be held in St. Augustine, May 12; Eustis, May 13; West Palm Beach, May 14; and Key West, May 15. The speaker at these meetings will be Dr. Walter J. Burdette of the Louisiana State University School of Medicine, New Orleans.

Dr. Courtlandt Berry of Orlando is on leave of absence from his practice in order to set up a cancer detection program for women at the University of Puerto Rico Medical School, San Juan.

Dr. Carl C. Mendoza of Jacksonville spoke and showed films on cancer to faculty members and students of the Jacksonville Junior College at a recent student assembly.

Dr. Frank L. Quillman of Sanford, Director of the Seminole County Health Unit, spoke to fellow members of the Sanford Lions Club recently. He explained the need of proper sewage disposal facilities to prevent future epidemics of typhoid or other diseases in the area.

Dr. P. G. Batson, Jr., of Pensacola spoke on "Medical Care of Polio Patients During Convalescence" during the third session of the Institute on Polio Care conducted at the Crippled Children's Convalescent Home in Pensacola.

Drs. William H. McCullagh and Matthew E. Morrow, Jr., of Jacksonville took part in a play depicting what happens to the mentally ill in Duval County at a meeting of the Northwest Florida Association for Mental Health in February. Dr. Sullivan G. Bedell of Jacksonville discussed the implications of the play after its presentation.

Dr. George W. Elarbee, Pahokee, was honored recently by the Pahokee Lions Club when they dedicated the club luncheon program to him and designated the day as Dr. George Elarbee Day. Though 78 years of age, Dr. Elarbee still practices medicine, serving his community four hours daily. During his 52 years of practice, he has delivered more than 2,300 babies.

Mr. Aubrey D. Gates, field director of the A. M. A. Council on Rural Health, visited Florida recently, attended a staff conference at the Association's office in Jacksonville and then proceeded to Tampa to confer with President David R. Murphey, Jr., and Dr. Eugene B. Maxwell, Chairman of the F. M. A. Committee on Public Relations, on the Association's Rural Educational Program.

Dr. Phillip W. Horn of Jacksonville talked on cancer to members and guests of the Lake Shore Dads Club on April 3. Dr. Horn demonstrated by chart how the incidence of cancer has increased in recent years. He described symptoms which each person, particularly those in the upper age groups, should watch for, and which when detected, should be taken immediately to a physician.

Dr. Donald W. Smith of Miami addressed a meeting of the South Florida Veterinary Society in March.

Dr. Grayson C. Snyder of Blountstown was recently elected vice president of the Blountstown Rotary Club.

Dr. Cornelia M. Carithers of Jacksonville spoke on "Sex Education for Children" at a meeting of the Junior Woman's Club of Jacksonville in March.

Dr. J. Clifford Boyce of Sanford spoke on the needs of underprivileged children at a recent meeting of the Kiwanis Club of Sanford.

Dr. Sidney Stillman of Jacksonville spoke on "Know Cancer's Seven Danger Signals" at the March meeting of the Lola M. Culver P.-T.A.

Dr. Fred H. Albee, Jr., of Orlando attended the Regional Meeting of the American College of Surgeons in San Juan, Puerto Rico, February 27-30.

Drs. James C. Lanier and Lorenzo L. Parks of Jacksonville were speakers at the opening session of a course in the current nursing methods of Polio treatment for Northwest Florida nurses in Jacksonville in March.

Dr. Kenneth A. Morris of Jacksonville presented a paper on "Surgery of the Pancreas" at the Southeastern Surgical Congress in Atlanta in March.

At its meeting in February The Greater Miami Eye, Ear, Nose and Throat Society, now in its fifth year, elected the following officers: President, Dr. Kenneth S. Whitmer of Miami; Vice President, Dr. John R. Richardson of Miami; Second Vice President, Dr. M. Austin Lovejoy of Fort Lauderdale; and Secretary-Treasurer, Dr. James H. Mendel, Jr., of Miami. The scientific program consisted of a discussion of "Unilateral Exophthalmos" with presentation of 10 cases by Dr. Ralph E. Kirsch and Dr. William Steinman of Miami, and a discussion of "Audiogram Interpretation" by Dr. Arthur L. Juers of Miami. Twenty-six members were present.

At a recent meeting of the Florida Society of X-Ray Technicians in Jacksonville, Dr. A. Judson Graves of that city delivered the address of welcome. Dr. Ivan Isaacs of Jacksonville spoke on "Angiocardiography," and Dr. Wade S. Rizk, also of Jacksonville, spoke on "Useful But Infrequently Used Positions in Skeletal Radiography."

Dr. Sherman B. Forbes of Tampa attended the annual meeting of the Georgia Society of Ophthalmology and Otolaryngology in Savannah on March 7 and 8.

Drs. Wilson T. Sowder and Frank G. Slaughter spoke at a meeting of the Florida Anti-Mosquito Control Association in Jacksonville recently. Dr. Sowder spoke on an effective mosquito control program, and Dr. Slaughter gave a talk on current health problems and their relationship to mental and emotional stress.

Dr. Milton C. Maloney of Jacksonville spoke on Cancer at a recent meeting of the Jacksonville Beaches Junior Woman's Club.

Dr. Russell B. Carson of Fort Lauderdale was elected president-elect of the Southeastern Section of the American Urological Association at the sixteenth annual meeting in Boca Raton, April 2-5. Dr. Carson had been serving as secretary-treasurer.

COMPONENT SOCIETY NOTES

Dade

At the regular May meeting of the Dade County Medical Association, the liaison Committee of the Dade County Bar Association presented a panel on the following subjects: "Confidential Relationship Between Doctor and Patient," "Duties and Responsibilities of the Court-appointed Physician," "The Duties of the Expert Medical Witness," and "The Responsibilities of Furnishing Medical Reports."

DeSoto-Hardee-Highlands-Glades

At the March meeting of the DeSoto-Hardee-Highlands-Glades Medical Society, Dr. S. L. Watson presented a paper on "Lesions of the Cervix."

Duval

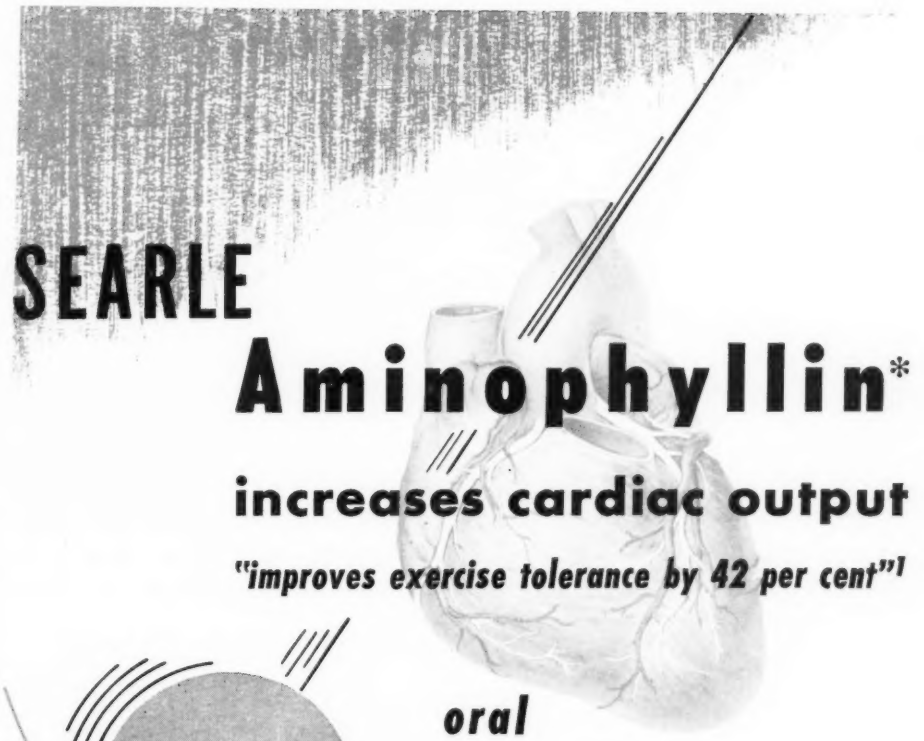
The Duval County Medical Society is cooperating with the Jacksonville-Duval County Civil Defense Council in sponsoring a second casualty team training course. Faculty for the nine-lecture course includes Drs. James V. Freeman, George W. Croft, J. Q. U. Thompson, Jonathon H. Wood, Thomas M. Irwin and Milton C. Maloney.

At the regular April meeting of the Duval County Medical Society, Dr. J. Hillis Miller, President, and Mr. Jefferson Hamilton, Architect, of the University of Florida, Gainesville, spoke on "Recent Developments in Medical Education in Florida," and Mr. DeWitt Dawkins spoke on "Housing Problems in Jacksonville." Dentists of the Northeast Florida District and members of the Jacksonville Dental Society were invited to attend the meeting.

Manatee

Dr. Theodore VanDellen, assistant professor of medicine and assistant dean of the Northwestern University Medical School, spoke on "The Follow Up Treatment of Coronary Thrombosis" at a combined meeting of the Manatee and Sarasota County Medical Societies, in March. Dr. VanDellen is author of the syndicated column, "How Is Your Heart?"

(Continued on page 812)



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1. Kissin, M.; Stein, J. J., and Adelman, R. J.: Angiology 2:217 (June) 1951.
2. Rickles, J. A. J. Florida M.A. 38:263 (Oct.) 1951.

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From where I sit, it's only too easy to forget how to do something—even as simple as milking a cow—if we don't keep at it. And that goes for practicing tolerance, too. Like forgetting our neighbor has a right to decide for himself—how to practice his profession . . . whether or not to have beer with his meals. If we don't keep the other fellow's point of view constantly in mind we're liable to have our freedoms "milked" away.

Joe Marsh

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(Continued from page 810)

Marion

The regular monthly meeting of the Marion County Medical Society was held at the Ocala Highlands Hotel on March 18. Guest speaker was Dr. Bruce Logue, assistant professor of medicine, Emory University School of Medicine, who presented an illustrated paper on "Indications for Cardiac Surgery."

Members of the Alachua County Medical Society present as guests included Drs. William C. Thomas, Sr.; Henry S. Blank; James M. McClamroch; and John E. Maines, Jr., all of Gainesville. Aso present were Ernest R. Gibson, assistant managing director, and Norman J. Ulbright, acting supervisor, Bureau of Public Relations, Florida Medical Association, and who, during their visit, conferred with Dr. Richard C. Cumming, chairman of the county public relations committee, and Dr. Eugene G. Peek, Sr., chairman of the Association's Committee on Legislation and Public Policy.

Orange

At the regular February meeting of the Orange County Medical Society, Dr. William A. Walter, Director, Division of Venereal Disease, Florida State Board of Health, conducted a round-table discussion on the interpretation of serology tests and treatment of syphilis.

Among the guests present were seven members of the Seminole County Medical Society.

At the March meeting of the Society, Dr. Leon Unger, Associate Professor of Medicine, Northwestern University, spoke on bronchial asthma; and Dr. Robert Glover, Clinical Professor of Thoracic Surgery, Hahnemann Hospital and Temple University, presented an illustrated talk on surgery of the mitral valve for relief of mitral stenosis.

Palm Beach

Dr. Albert F. R. Andresen, Brooklyn, N. Y., clinical professor emeritus of the medical center, New York City College of Medicine, addressed the Palm Beach County Medical Society at its monthly meeting in February.

Pinellas

The series of medical public forums sponsored by the Pinellas County Medical Society in cooperation with the St. Petersburg Times was praised in a recent issue of The PR Doctor, issued by the A. M. A. Department of Public Relations. The project was also hailed by Editor and Publisher, weekly trade magazine.

Sarasota

Members of the Sarasota County Medical Society met with the Manatee County Medical Society in March to hear a talk on "The Follow Up Treatment of Coronary Thrombosis" by Dr. Theodore VanDellen, assistant professor of medicine and assistant dean of the Northwestern University Medical School.

Suwannee

The Suwannee County Medical Society, in conjunction with the Suwannee County Health Department, the Florida State Board of Health and the American Cancer Society presented the Third Annual Cancer Seminar in Live Oak March 20.

BOOKS RECEIVED

Standard Nomenclature of Diseases and Operations. Edited by Richard J. Plunkett, M.D., Editor, and Adaline C. Hayden, R.R.L., Associate Editor. Ed. 4. Pp. 1,014. Price, $8.00. Published for The American Medical Association. Philadelphia, The Blakiston Company, 1952.

This fourth edition of the standard guide to disease and operation recording for medical record librarians and physicians has been completely revised and brought up-to-date in keeping with medical progress. Sponsored by the American Medical Association, it is the result of three years of extensive work by an editorial advisory board and 21 committees representing each of the individual or specialty sections of the book.

Code numbers for acute and chronic conditions are made consistent, new heart diagnoses are included, diseases of the Hemic and Lymphatic systems are revised to conform to accepted terminology, the dental and tuberculosis sections are enlarged, and the section on operations includes new operative procedures used in skin grafts and cardiac surgery. Also, the supplementary terms are placed in one section and the disease and operations indexes are placed consecutively in the book.

In addition to these revisions, an International Statistical Classification of Diseases, Injuries and Causes of Death is included. These code numbers are cross-referenced to the "Standard" code numbers.

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Migraine In Children

"Migraine may appear during the first years of life. The presence of subjective signs, such as headache and flimmer scotoma, is often difficult to determine in young children. The true nature of the symptoms frequently remains obscure for years."

Vahlquist, B. and Hackzell, G.: Acta Paediatrica *38*: 622 (1949).

NO. OF CASES	SEX	AGE AT ONSET	CYCLIC VOMITING	DURATION OF ATTACK	INTENSITY
31	8 ♀ 23 ♂	3 yrs. (mean)	3 out of 31	2½ hrs.	severe in all cases

TABLE CONT'D

NO. OF CASES	UNILATERAL HEADACHE	NAUSEA	FLIMMER SCOTOMA	VERTIGO	HEREDITY
31	18 out of 31	31 out of 31	12 out of 31	6 out of 31	20 out of 31

(reference given above)

In a study of 400 adult migraine patients, it was revealed that 34% had suffered attacks before the age of 15.* These investigators concluded that childhood migraine was a much greater clinical problem than was previously believed and that psychodynamic mechanisms played an important part in the disease.

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In the adolescent age group, 12 to 18 years of age, the dosage may gradually be increased as necessary up to the usual adult dose, i.e., two tablets when the attack appears imminent followed by one tablet doses at half hour intervals until the attack is aborted. *(Total maximum dose for adults: six tablets for each attack.)*

*Katz, J., Friedman, A.P., and Gisolfi, A.: New York State J. Med. *50*: 2269 (Oct.) 1950.

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OBITUARIES

Henry Oscar Snow

Dr. Henry O. Snow of Tampa died at his home on Feb. 18, 1952. He was 75 years of age.

A native Floridian, Dr. Snow, the son of Henry O. and Sarah G. Snow, was born in Brooksville in 1876. He received his early education in Spartanburg, S. C., and the degree of Doctor of Medicine from the Atlanta College of Physicians and Surgeons in 1900. Since 1907 he had engaged in the practice of medicine in Tampa, specializing in surgery.

A veteran of the Spanish-American War, Dr. Snow served as a major in the Medical Corps during World War I. He was later assigned to the Public Health Service for Florida with headquarters in Tampa. He also served as Hillsborough County Physician. Locally, he was a member of the American Legion and the Palma Ceia Golf Club.

A Masonic leader, Dr. Snow was high priest, Tampa Chapter 3, Royal Arch Masons; past master, Tampa Council No. 8; past eminent commander, Tampa-Ivanhoe Commandery, Knights Templar; past grand high priest of the Royal Arch Masons of Florida; past most illustrious grand master of the Grand Council of Florida; past grand commander of the Grand Commandery, Knights Templar, Florida; past sovereign of St. Sebastian Conclave No. 27, Knights of Constantine; Knight of the York Rite Cross of Honor; member of Egypt Temple Nobles of the Mystic Shrine; past patron of Tampa Chapter No. 11, Order of the Eastern Star, and a past grand patron of the Grand Chapter of Florida, Order of the Eastern Star.

Dr. Snow was a member of the Hillsborough County Medical Association and the Florida Medical Association, of which he had been a life member for six years. He was also a member of the American Medical Association and the Southern Medical Association.

Surviving are the widow, Mrs. Douglas Snow, and a son, Oscar D. Snow, of Tampa; also four sisters, Mrs. Anna Davis of Tampa, Mrs. J. M. Spencer of Atlanta, Ga., Mrs. A. G. Evans of Monto Park, Calif., and Mrs. O. S. Nelson of Coral Gables; and three brothers, A. C. Snow of Pensacola, Proctor Snow of Dublin, Ga., and H. L. Snow of Cocoa.

Clarence M. Sandusky

Dr. Clarence M. Sandusky of Jacksonville died on Dec. 29, 1951 in Jefferson Hospital in Philadelphia after a brief illness. He was 74 years of age.

Born in Nicholasville, Ky., in 1877, Dr. Sandusky received his medical education in his native state. He was awarded the degree of Doctor of Medicine by the University of Louisville School of Medicine in 1902.

For a short time he engaged in the practice of medicine in Crescent City. He then located in Jacksonville, where he limited his practice to otorhinolaryngology and was physician for the Seaboard Air Line and Atlantic Coast Line railroads.

This prominent physician was also a financier of note and president of the Title and Trust Company of Florida. He enjoyed broad interests. An outstanding amateur horticulturist, he was a poineer in the raising of camellias. One camellia which originated in his gardens is named for his widow, Mrs. Margaret Sandusky, who alone survives him.

Dr. Sandusky was a member of the Duval County Medical Society. Since 1906 he had been a member of the Florida Medical Association, for the last 12 years a life member. He also held membership in the American Medical Association.

NOTICE

This May Journal carries the new officers and committeemen with the exception of the president-elect, vice presidents, secretary-treasurer and editor of The Journal. The names of these officers are omitted because the May Journal went to press before the election of officers by the House of Delegates, April 30.

All new officers will be listed in your June Journal, as will be the personnel of The Journal staff for 1952.

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting May 12, June 2, June 16. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting June 2, September 8. Surgical Anatomy & Clinical Surgery, Two Weeks, starting June 16, September 22. Surgery of Colon & Rectum, One Week, starting May 12, June 2. Gallbladder Surgery, Ten Hours, starting June 16. Basic Principles in General Surgery, Two Weeks, starting September 8. General Surgery, One Week, starting May 12, October 6. Breast & Thyroid Surgery, One Week, starting June 23. Esophageal Surgery, One Week, starting June 23. Thoracic Surgery, One Week, starting June 2. Fractures & Traumatic Surgery, Two Weeks, starting June 16.

GYNECOLOGY—Intensive Course, Two Weeks, starting June 16. Vaginal Approach to Pelvic Surgery, One Week, starting June 9, September 22.

OBSTETRICS—Intensive Course, Two Weeks, starting June 2, September 29.

PEDIATRICS—Informal Clinical Course every two weeks. Cerebral Palsy, Two Weeks, starting July 7.

MEDICINE—Electrocardiography & Heart Disease, Two Weeks, starting July 14. Gastroenterology, Two Weeks, starting May 19. Hematology, One Week, starting June 16. Gastroscopy & Gastroenterology, One Week Advanced Course, June 23.

CYSTOSCOPY—Ten Day Practical Course starting May 26, June 9, July 7.

DERMATOLOGY—Intensive Course, Two Weeks, starting October 13.

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NOTICE

Old officers and committee chairmen appear in this May Journal since it went to press before the election of officers at the annual meeting, April 28. New officers and committee chairmen will appear in your June Journal.

"Snake in the Grass"

If an alarm went out that there was a "snake in the grass," to a group of people in a certain field, a sudden caution would be exerted by those whose work kept them in that area. They would want to know, "Where?" and "What kind?" The snake in this case is turned loose in the field of medicine; its nature is sinister because it can damage those who are caught unaware; its species, propaganda.

On the Caduceus, which is the insignia of the physician, are two serpents wreathed around a staff, topped with wings; formerly it was identified with Mercury but which became the symbol of a great medical tradition. This symbol has

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*Lane, C. G., Therapeutic Dermatitis, New Eng. J. Med., 246:77-81, 1952

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been used by a modern author to the detriment of its real meaning in a book called "The Serpent-Wreathed Staff." In effect, the serpents have been released from the staff to slither among the grass roots of medicine causing regrettable confusion.

Whatever reason Mrs. Alice Tisdale Hobart had in the writing of this book she has succeeded in alarming the medical profession by her inaccurate treatment of a serious, national subject; she has pleased the proponents of compulsory health measures by the same action. This fact alone identifies the problem and emphasizes the continuing importance of being alert and informed so that we can intelligently counteract the false impressions a book of this type can create. It proves that our efforts in education are still of paramount importance. We must understand what we stand for in order to defend it as well as to interpret it to others. We lack the appeal of the romantic figure in that piece of fiction but we can help stabilize the resultant confusion with calm logical fact — if we acquire those facts.

This is our responsibility. Discover the source and nature of the threat; take steps to combat it, and be vigilant — for as in the parable of the weeds we are like the man who sowed good seed in his field; but while men were asleep, his enemy came and sowed weeds among the wheat and went away.

Mrs. C. Robert DeArmas.

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Dr. Wm. Dameshek, Tufts Medical College, Advances in Hematology.
Dr. D. C. Darrow, Yale University, Electrolyte Disturbances.
Dr. R. Elman, Washington University, Recent Advances in Surgery.
Dr. J. W. Hinton, New York University, Advances in Gastric Surgery.
Dr. J. B. Kirsner, University of Chicago, Gastrointestinal Diseases.
Dr. R. Levine, Michael Reese Hospital, Adreno-Cortical Steroids; also Recent Advances in Diabetes.
Dr. J. H. Means, Harvard University, Advances in Thyroidology and Clinical Applications.
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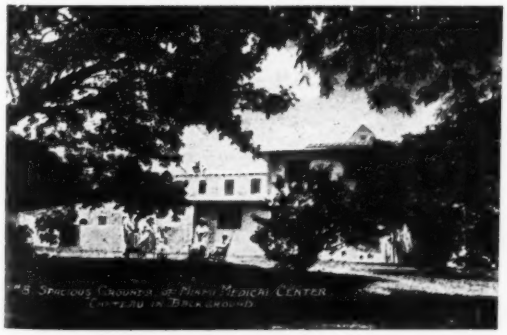

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